Anthem Blue Cross and Blue Shield

SmartValue (PFFS) Evidence of Coverage

The Advantage is Yours



This booklet is your SmartValue (PFFS) Evidence of Coverage (EOC). For questions regarding your coverage, please call Customer Service, 7 days a week, from 8 a.m. to 9 p.m. at 1-877-326-2201. TTY/TDD: 1-800-425-5705



EVIDENCE OF COVERAGE

January 1, 2010 – December 31, 2010

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Anthem SmartValue (PFFS)

This booklet gives you the details about your Medicare health and prescription drug coverage from **January 1, 2010 – December 31, 2010**. It explains how to get the health care and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Customer Service:

For help or information, please call Customer Service or go to our plan website.

1-877-326-2201 (Calls to these numbers are free.)

TTY/TDD users call: 1-800-425-5705 Website: www.anthem.com/medicare

Hours of Operation:

8 a.m. to 9 p.m. 7 days a week

This plan is offered by Anthem Blue Cross and Blue Shield, referred to throughout the Evidence of Coverage as "we," "us," or "our." Anthem SmartValue is referred to as "plan" or "your plan."

A health plan with a Medicare contract.

This information may be available in a different format, including other languages and large print. Please call Customer Service at the number listed above if you need plan information in another format or language.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

Your 2010 Medical Benefit Chart PFFS Plan 0

Maine State Employees Health Insurance Program Effective 01/01/2010

Covered Services	What you must pay for these covered services
Inpatient Services	

Inpatient hospital care

Hospital days are unlimited. Covered services include, but are not limited to, the following:

- Semi-private room (or a private room if medically necessary).
- Meals including special diets.
- Regular nursing services.
- Costs of special care units (such as intensive or coronary care units).
- Drugs and medications.
- Lab tests.
- X-rays and other radiology services.
- Necessary surgical and medical supplies.
- Use of appliances, such as wheelchairs.
- Operating and recovery room costs.
- Physical therapy, occupational therapy, and speech therapy services.
- *Under certain conditions, the following types of transplants are covered:* Corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.
- Blood including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.
- Physician services.

For Medicarecovered hospital stays:

\$0 copay per admission

No limit to the number of days covered by the plan each benefit period.

Covered Services	What you must pay for these covered services
Inpatient mental health care	
Includes mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital.	For Medicare- covered Hospital Stays: \$0 copay per admission
Skilled nursing facility care	
Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.	For Medicare- covered SNF stays: \$0 copay per admission
Covered services include, but are not limited to, the following:	r
 Semi-private room (or a private room if medically necessary). Meals, including special diets. Regular nursing services. Physical therapy, occupational therapy, and speech therapy. Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. Medical and surgical supplies. Laboratory tests. X-rays and other radiology services ordinarily provided by SNF's. Use of appliances such as wheelchairs ordinarily provided by SNF's. Physician services. No prior Hospital stay required. 	

Covered Services	What you must pay for these covered services
Inpatient services covered when the hospital or SNF days aren't or are no longer, covered	
Covered services include:	
Physician services.	
• Tests (like X-ray or lab tests).	After your SNF
 X-ray, radium, and isotope therapy including technician materials and services. 	day limits are used up, the plan
• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.	will still pay for covered physician
 Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. 	outlined in this
• Leg, arm, back, and neck braces; trusses, and artificial legs arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.	

Home health agency care

Covered services include:

- Part-time or intermittent skilled nursing and home health aide services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and thirty-five or fewer hours per week.)
- Physical therapy, occupational therapy, and speech therapy.
- Medical social services.
- Medical equipment and supplies.

\$0 copay for Medicare-covered home health visits

Covered Services

What you must pay for these covered services

Hospice care

You may receive care from any Medicare-certified hospice program. Original Medicare plan (rather than our plan) will pay the hospice provider for the services you receive. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan.

Covered services include:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare.
- Home care.
- Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

You must receive care from a Medicarecertified hospice. When you enroll in a Medicarecertified hospice program, your hospice services are paid for by the Original Medicare Plan, not vour Medicare Advantage plan. You pay \$0 copay for the one time only hospice consultation.

Outpatient Services

Physician services, including doctor office visits

Covered services include:

- Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center.
- Consultation, diagnosis, and treatment by a specialist.
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment.
- Telehealth office visits including consultation, diagnosis and treatment by a specialist.
- Second opinion by another plan provider prior to surgery.
- Outpatient hospital services.
- Non-routine dental (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation).

\$0 copay per visit to a primary care physician (PCP) for Medicarecovered services \$0 copay per visit to a specialist for Medicare-covered services

Covered Services	What you must pay for these covered services
Physician services, including doctor office visits (cont)	Excess charge-
 Treatments of neoplastic cancer disease or services that would be covered when provided by a doctor. 	Plan covers up to 115% of Medicare allowed amount if the provider does
Excess Charge- Providers who do not accept Medicare assignment may bill up to 15% above the Medicare approved amount.	not accept Medicare assignment.
Chiropractic services	
Covered services include:	\$0 copay for each Medicare-covered
• Manual manipulation of the spine to correct subluxation.	visit
 Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. 	
Podiatry services	
 Treatment of injuries and disease of the feet (such as hammer toe or heal spurs). 	\$0 copay for each Medicare-covered visit
 Medicare-covered routine foot care for member with certain medical conditions affecting the lower limbs. 	VISIT
• Foot exams: A foot exam is covered every six 6 months for people with diabetic peripheral neuropathy and loss of protective sensations.	
Outpatient mental health care (including Partial Hospitalization Services)	
Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	\$0 copay for each Medicare-covered individual or group therapy visit

Covered Services	What you must pay for these covered services
Outpatient substance abuse services	\$0 copay for each Medicare-covered individual or group therapy visit
Outpatient surgery (Includes services provided at ambulatory surgical centers.) Facilities where surgical procedures are performed; and, the patient is released the same day.	\$0 copay for each Outpatient Hospital Facility or Ambulatory Surgical Center visit for surgery
Ambulance services Covered ambulance services include fixed wing, rotary wing and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required. Ambulance service is not covered for physician office visits.	\$0 copay for Medicare-covered ambulance services
 This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition. 	\$0 copay for each Medicare-covered emergency room visit

Covered Services	What you must pay for these covered services
Urgently needed care	¢0 f1
• Urgent care is available on a world-wide basis.	\$0 copay for each Medicare-covered urgently needed care visit
• If you are outside of the service area for your plan, your plan covers urgently needed care, including urgently required renal dialysis.	
Comprehensive Outpatient Rehabilitation Facility (CORF) services	
(physical therapy, occupational therapy, cardiac rehabilitation, pulmonary rehabilitation and speech and language therapy)	\$0 copay per visit for Medicare-
Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris, have had a heart valve repair/replacement, angioplasty or coronary stenting, or have had a heart or heart-lung transplant.	covered outpatient rehabilitation services
Durable medical equipment (DME) and related supplies	\$0 copay on all Medicare-covered DME and related supplies
This includes but not limited to, wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	
Prosthetic devices and related supplies	
Devices (other than dental) that replace a body part or function. These include but not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" for more detail.	\$0 copay on all Medicare-covered Prosthetic and related supplies

Covered Services	What you must pay for these covered services
Diabetes self-monitoring training and supplies	For Medicare-
 Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. One pair per year of therapeutic shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. Self-management training is covered under certain conditions. For persons at risk of diabetes: fasting plasma glucose tests are covered. 	sovered services: \$0 copay for a 30 day supply on each purchase of glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors \$0 copay for blood glucose monitor and therapeutic shoes \$0 copay for self- management training \$0 copay for fasting plasma glucose tests covered up to twice a year
Medical nutrition therapy	
For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	\$0 copay for each Medicare- covered visit
Outpatient diagnostic tests and therapeutic services and supplies Covered services include:	\$0 copay for each Medicare-covered
• X-rays.	x-ray visit

Covered Services	What you must pay for these covered services
Outpatient diagnostic tests and therapeutic services and	
supplies (cont)	\$0 copay for
Complex diagnostic tests and x-rays.Radiation therapy.	Medicare-covered complex
Laboratory tests.	diagnostic test and x-ray services
 Surgical supplies, such as dressings. 	
 Supplies, such as splints and casts. Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. Diagnostic tests and x-rays are considered complex and include heart catheterizations, sleep studies, computer tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans. 	\$0 copay for each Medicare-covered radiation therapy & chemotherapy treatment \$0 copay for Medicare-covered clinical/diagnostic lab test \$0 copay for supplies \$0 copay per pint of blood
Vision care Covered services include:	For Medicare- covered services:
 Outpatient physician services for eye care. 	
• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.	\$0 copay for exams to diagnose and treat diseases of the eye.
• Eye Exams: An eye exam to check for diabetic retinopathy once every twelve (12) months.	\$0 copay for glaucoma
 One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. 	\$0 copay for glasses/ contacts following cataract surgery

Covered Services	What you must pay for these covered services
Preventive Care and Screening Tests	
Abdominal aortic aneurysm screening	
A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	\$0 copay for Medicare-covered screening
Bone mass measurements	\$0 copay for visits
For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	to primary care physicians (PCP) for Medicare-covered bone mass measurement \$0 copay for visits to physician specialists for Medicare-covered bone mass measurement
Colorectal screening	
For people 50 and older, the following are covered:	\$0 copay for visits
 Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. 	to primary care physicians (PCP) for Medicare-
• Fecal occult blood test, every 12 months.	covered screenings
For people at high risk of colorectal cancer, the following are covered:	\$0 copay for visits to physician specialists for Medicare-covered screenings
 Screening colonoscopy (or screening barium enema as an alternative) every 24 months. 	
For people not at high risk of colorectal cancer, the following is covered:	
• Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	

Covered Services	What you must pay for these covered services
Immunizations	
Covered services include:	\$0 copay for
 Pneumonia vaccine. Flu shots, once a year in the fall or winter. If you are at high or intermediate risk of getting Hepatitis B: 	Medicare-covered immunizations
Hepatitis B vaccine.Other vaccines if you are at risk.	
If Part D prescription drug coverage is included with your medical plan, we also cover some vaccines under our outpatient prescription drug benefit.	
Mammography screening	
Covered services include:	\$0 copay for Medicare-covered
• One baseline exam between the ages of 35 and 39.	screening exams
 One screening every 12 months for women age 40 and older. 	
Pap test, pelvic exams, and clinical breast exam	
Covered services include:	\$0 copay for
For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months.	Medicare-covered screening exams
If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.	
Prostate cancer screening exams	\$0 copay for visits
For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	to primary care physicians (PCP) for Medicare- covered screening exams
	\$0 copay for visits to physician specialists for Medicare-covered screening exams

Covered Services	What you must pay for these covered services
Cardiovascular disease testing	
Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) every five years.	\$0 copay for Medicare-covered tests
Other Services	
Physical exams	
Routine physical exams (limited to one exam per year) are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are not required by third-party (i.e., insurance companies, business establishments, governmental agencies).	\$0 copay for visits to primary care physicians (PCP) \$0 copay for visits to physician
Routine labs and x-rays ordered in conjunction with the physical exam are covered under "Outpatient diagnostic tests and therapeutic services and supplies" unless otherwise specified in this benefit chart.	specialists
Dialysis (Kidney)	
Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area).	For Medicare-covered services: \$0 copay for
 Inpatient dialysis treatments (if you are admitted to a hospital for special care). Self-dialysis training (includes training for you and others for the person helping you with your home dialysis 	Inpatient dialysis copay applies to inpatient dialysis.
treatments). • Home dialysis equipment and supplies.	\$0 copay for self- dialysis training
 Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). 	\$0 copay for home dialysis equipment and supplies
Medicare Part B prescription drugs	
"Drugs" includes substances that are naturally present in the body, such as blood clotting factors. Drugs that usually are not self-administered by the patient	\$0 copay for Medicare Part B covered drugs.

Covered Services

What you must pay for these covered services

Medicare Part B prescription drugs (cont)

- and are injected while receiving physician services. This plan also covers some drugs that are "usually not self-administered" even if you inject them at home.
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan.
- Clotting factors you give yourself by injection if you have hemophilia.
- Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to postmenopausal osteoporosis, and cannot self-administer the drug.
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Certain drugs for home dialysis, including heparin, the
- antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®).
- Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.

If Part D prescription drug coverage is included with your medical plan, please refer to your Evidence of Coverage for information on your Part D prescription drug benefits.

\$0 copay for Medicare-covered chemotherapy drugs.

Additional Benefits

Hearing services

- Routine hearing exams are covered once every two years.
- Hearing aids.

Routine hearing exams are limited to a \$50 benefit maximum.

\$0 copay for routine hearing exams.

\$50 benefit maximum is waived for this plan

No coverage for hearing aids.

Covered Services	What you must pay for these covered services
Routine Vision Care	\$0 copay
 Routine vision exams 	for routine vision exams
• Eye wear	\$50 benefit
Routine vision exams are limited to a \$50 benefit maximum.	maximum is waived for this plan
	No coverage for routine eye wear.
Health and Wellness education programs	
SilverSneakers®	
You can enroll in this program. A fitness plan designed especially for Medicare-eligible individuals. SilverSneakers® includes:	\$0 copay for the Silver Sneakers fitness benefit
 A complimentary basic membership in a participating fitness center in your area. You can use all the services available to fitness center members with a basic membership, such as steam and sauna rooms, exercise equipment, and SilverSneakers® classes custom-designed for all levels of fitness. 	
 Opportunities to join in fitness promotions and health education seminars. 	
There is not a separate charge for this program, as long as you only use services available with basic fitness center memberships.	
After you enroll in this Medicare Advantage plan, you will receive a brochure that shows the participating fitness centers in your area and describes how to enroll in SilverSneakers.	
Contact Customer Service for more information on this program, or visit www.SilverSneakers.com.	
Smoking Cessation (Counseling to quit smoking)	
Up to eight (8) face-to-face visits in a twelve (12) month period if you are diagnosed with an illness caused or complicated by tobacco use; or, you take a medication that is affected by tobacco. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	\$0 copay for each Medicare-covered visit

Covered Services	What you must pay for these covered services
Foreign travel inpatient, emergency and urgently	\$0 copay for
needed care	Emergency Care
 Emergency or urgent care services while traveling outside the United States during a temporary absence of less than 6 months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. Emergency outpatient care. Urgent care. Inpatient care (60 days per lifetime, 80% to \$50,000 lifetime maximum for inpatient care). 	\$0 copay for Urgent Care \$250 deductible and 20% coinsurance for inpatient care until lifetime maximum is reached
Non-emergent care.	Not covered for non-emergent care.
Annual Out of Pocket Maximum All coinsurance, copayments and deductibles for Medicare-covered services listed in this benefit chart are accrued toward the medical plan out of pocket maximum with the exception of routine vision, routine hearing, the foreign travel emergency and urgently needed care copays specific to foreign travel and the foreign travel inpatient deductible and coinsurance. Medicare part D Prescription drug deductibles, copays and cost shares do not apply to the medical plan out of pocket maximum.	\$0

You must receive all services (except emergency care) from doctors, specialists and hospitals that agree to accept the plan terms and conditions of payment in order to have those services covered by this plan.

ADDITIONAL SERVICES Not Covered by Medicare	
Annual Deductible	\$100
Lifetime Maximum	\$1,000,000
Chiropractic Services Benefits are provided for ancillary treatment such as massage therapy, heat and electro-stimulation in conjunction with an active course of treatment. Benefits are not provided for maintenance therapy for chronic conditions.	20% coinsurance after deductible is met
Acupuncture	
The services of a licensed acupuncturist or Doctor of Chinese Medicine for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.	20% coinsurance after deductible is met
Chinese herbs and supplements excluded.	
Temporomandibular Joint Syndrome (TMJ)	
Coverage is provided for the treatment of a specific organic condition of or physical trauma to the temporomandibular joint (jaw hinge). Coverage is limited to surgery or injections of the temporomandibular joint, physical therapy, or other medical treatments	20% coinsurance after deductible is met
Benefits are not provided for any temporomandibular joint syndrome services not listed as covered in the Covered Services section. Coverage is not provided for any procedure or device that alters the vertical relationship of the teeth or the relation of the mandible to the maxilla. Dental services related to TMJ are not covered.	

Stockings 20% coinsurance after Benefits are provided for stockings such as Linton, Jobst deductible is met and Sigvaris stockings only when provided for postsurgical use or when prescribed for circulatory diseases. Wigs/Hairpieces Only covered for certain diseases, injuries, congenital or developmental anomalies, or previous therapeutic processes, resulting in temporary or permanent hair loss. Must be ordered by a physician. Only covered for certain diseases, injuries, congenital or developmental anomalies, or previous therapeutic processes, resulting in temporary or permanent hair loss. Must be ordered by a physician. Limit two per calendar year.

Traumatic or surgical scalp avulsion, burns, alopecia areata or totalis. Medical conditions documented by tests and other diagnostic measures resulting in permanent or temporary hair loss. Conditions or injuries being actively treated with an accepted and covered treatment that have resulted in temporary hair loss.

Note: If covered, wigs/hairpieces are considered to be a prosthetic and would be subject to any product-specific calendar year limits for prosthetics.

The following is a list of **exclusions** for wigs or hairpieces due to:

- Aging.
- Male pattern baldness or premature old age.
- Medical conditions which cannot be documented by tests and other diagnostic measures resulting in hair loss.
- The cleaning and maintenance of hairpieces.

20% coinsurance after deductible is met

Dental Services

Dental Services Benefits are provided only for the following teeth and jaw services:

- Setting a jaw fracture;
- Removing a tumor or cyst (but not a root cyst);
- Removing impacted or unerupted teeth in a non-hospital or non-rural health center setting;
- Repairing or replacing dental prostheses damaged by an accidental bodily injury;
- Treating accidental bodily injury to natural teeth;
- Emergency stabilization treatment for accidental injury to natural teeth if initiated and completed within 72 hours of the injury or accident;
- Biopsy and excision of a lesion;
- Gingivectomy or gingoplasty (per quadrant per tooth);
- Gingival flap procedure (including root planning per quadrant);
- Osseous surgery (including flap entry and closure per quadrant);
- Osseous surgery or graft; single site or multiple sites (including flap entry, closure, and donor sites);
- Pedicle soft tissue graft;
- Free soft tissue graft (including donor site);
- Apically repositioned flap procedure;
- Excision of partially or completely unerupted teeth;
- Excision of a tooth root without the extraction of the entire tooth;
- Suturing of dental surgical incision;
- Cancer-related dental services; and
- Other incision or excision of the gums or tissues of the mouth.
- Some of the services listed above may also be covered under your dental plan.

20% coinsurance after deductible is met

Your 2010 Prescription Drug Benefit Chart Premier 10/30/45

Maine State Employees Health Insurance Program Effective - 01/01/2010

Formulary	Premier 3 Tier - Open
Mandatory Generic	No
Deductible	\$0
Covered Services	What you pay
Initial Coverage	
To 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 11 10 1

Below is your payment responsibility from the time you meet your deductible, if you have one, until the cost paid by you for your prescriptions reaches your True Out of Pocket cost of \$4,550.

Retail Pharmacy	per up to 59 days supply
 Generics, including Specialty Drugs 	\$10 copay
	\$0 copay for Select Generics
 Select Generics 	
Preferred Brands, including Specialty Drugs and Vaccines	\$30 copay
Non-Preferred Brands and Non-Formulary Drugs	\$45 copay

Typically retail pharmacies dispense a 30-day supply of medication. Most of our retail pharmacies can dispense up to a 90-day supply of medication. If you use a retail pharmacy in the State of Maine that will distribute a 60 to 90 day supply, the Mail Order Pharmacy copays (shown below) will apply.

Mail Order Pharmacy	per 60 to 90 day supply
Generics, including Specialty Drugs	\$10 copay
Select Generics	\$0 copay for Select Generics
 Preferred Brands, including Specialty Drugs and Vaccines 	\$30 copay
 Non-Preferred Brands and Non-Formulary Drugs 	\$45 copay

Covered Services What you pay

If you purchase drugs at Retail or Mail Order Pharmacies that are not listed in our participating pharmacy directory, you will be responsible for all amounts over our negotiated cost. If you need an emergency supply of drugs and you are not near a Retail Pharmacy in our participating pharmacy directory, you will not be responsible for amounts over our negotiated costs.

Vaccine Coverage

The up front costs for vaccines will vary based upon where the vaccine is purchased and administered. Some vaccines, such as Flu Vaccines, are paid under your Medicare Part B coverage. Vaccines that are covered by Medicare Part B are not covered by your Part D plan. Please see your Evidence of Coverage booklet for a complete explanation of your vaccine coverage.

Catastrophic Coverage

Your payment responsibility changes after the cost you have paid for prescription drugs reaches your True Out of Pocket cost of \$4,550.

<i>j</i>	
 Generics, including Specialty Drugs 	\$2.50 or 5% whichever is greater
Select Generics	\$0 copay for Select Generics
 Preferred and Non-Preferred Brands, including Specialty Drugs, Vaccines, and Non-Formulary Drugs 	\$6.30 or 5% whichever is greater

Extra Covered Drug Groups

These are drugs that are covered by your plan that are often excluded from Part D Prescription Drug Plans. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.

Reprodigatorings and Raphiturates.

See Formulary for complete list.

Benzodiazepines and Barbiturates	See Formulary for complete list
Cosmetics	of drugs covered
Cough and Cold	
DESI	
Over the Counter Vitamins and Minerals	
Analgesics	
Generics	You pay your retail or mail order generic
	copay
Preferred and Non-Preferred Brands	You pay your retail or mail order generic
	copay
Erectile Dysfunction	See Formulary for complete list
·	of drugs covered
• Generics	\$50 copay
Preferred and Non-Preferred Brands	\$50 copay
Infertility Drugs	None of these drugs are Formulary drugs
• Generics	\$50 copay
• Brands	\$50 copay

TABLE OF CONTENTS

This list of chapters and page numbers is just your starting point.

For more help in finding information you need, go to the first page of a chapter.

You will find a detailed list of topics at the beginning of each chapter.

Chapter		Page
1.	Getting started as a member	2
	Tells what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.	
2.	Important phone numbers and resources	11
	Tells you how to get in touch with our plan and with other organizations including Medicare, the State Health Insurance Assistance Program, the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
3.	Using the plan's coverage for your medical services Explains important things you need to know about getting your medical care as a member of our plan such as how to get care when you have an emergency.	19
4.	Medical benefits (What is covered and what you pay)	29
5.	Using the plan's coverage for your Part D	
	Explains rules you need to follow when you get your Part D drugs. Tells how to use our plan's List of Covered Drugs (Formulary). Tells which kinds of drugs are not covered. Explains several kinds of restrictions that apply to your coverage for certain drugs. Explains where to get your prescriptions filled. Tells about our plan's programs for drug safety and managing medications.	35

TABLE OF CONTENTS (con't)

This list of chapters and page numbers is just your starting point.

For more help in finding information you need, go to the first page of a chapter.

You will find a detailed list of topics at the beginning of each chapter.

Chapter		Page
6.	What you pay for your Part D prescription drugs. Tells about the stages of drug coverage including Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage and how these stages affect what you pay for your drugs. Explains the cost-sharing tiers for your Part D drugs. This chapter and the Benefit Chart located in the front of this booklet, tells what you must pay as your share of the cost for a drug in each cost-sharing tier. Tells about the late enrollment penalty.	53
7.	Asking the plan to pay its share of a bill you have received for covered services or drugs	68
	Tells when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services.	
8.	Your rights and responsibilities	74
	Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	
9.	What to do if you have a problem or complaint	
	(coverage decisions, appeals, complaints)	88
	Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.	
	 Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon. 	
	 Explains how to make complaints about quality of care, waiting times, Customer Service, and other concerns. 	

TABLE OF CONTENTS (con't)

This list of chapters and page numbers is just your starting point.

For more help in finding information you need, go to the first page of a chapter.

You will find a detailed list of topics at the beginning of each chapter.

Chapter		Page
10.	Ending your membership in the plan	. 143
	Tells when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
11.	Legal notices Includes notices about governing law and about nondiscrimination.	. 152
12.	Definitions of important words Explains key terms used in this booklet.	. 154
13.	State organization contact information Tells you how to get in touch with other organizations, including the State Health Insurance Assistance Program, the Quality Improvement Organization, etc.	. 161

1.

Getting started as a member

Section	Contents	Page
1.	Introduction	2
1.1	What is this Evidence of Coverage booklet about?	2
1.2	What does this Chapter tell you?	2
1.3	What if you are new to our plan?	2
1.4	Legal information about the Evidence of Coverage	3
2.	What makes you eligible to be a plan member?	3
2.1	Your eligibility requirements	3
2.2	What are Medicare Part A and Medicare Part B?	4
2.3	Here is the plan service area for our plan	4
3.	What other materials will you get from us?	4
3.1	Your plan membership card – use it to get all covered care and drugs	4
3.2	The Pharmacy Directory: your guide to pharmacies in our network	5
3.3	The plan's List of Covered Drugs (Formulary)	5
3.4	Reports with a summary of payments made for your prescription drugs	6
4.	Your monthly premium	6
4.1	How much is your plan premium?	6
4.2	Can we change your monthly plan premium during the year?	8
5.	Please keep your plan membership record up to date	9
5.1	How to help make sure that we have accurate information about you	9

Chapter

1.

1. Introduction

1.1 What is the Evidence of Coverage booklet about?

This Evidence of Coverage booklet tells you how to get your Medicare medical care and prescription drugs through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

- You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Anthem SmartValue.
- There are different types of Medicare Advantage Plans. Anthem SmartValue is a Medicare Advantage Plan PFFS (PFFS stands for Private Fee-for-Service).

This plan is offered by Anthem Blue Cross and Blue Shield, referred to throughout the Evidence of Coverage as "we," "us," or "our." Anthem SmartValue is referred to as "plan" or "your plan."

The words "coverage" and "covered services" refer to the medical care, services and the prescription drugs available to you as a member of Anthem SmartValue.

1.2

What does this Chapter tell you?

Look through Chapter 1 of this Evidence of Coverage to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- What is your plan's service area?
- How do you keep the information in your membership record up to date?

1.3

What if you are new to your plan?

If you are a new member, then it's important for you to learn how the plan operates — what the rules are and what services are available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact Customer Service (phone numbers are listed on the front cover of this booklet).

Chapter

1.4 Legal information about the Evidence of Coverage

It's part of our contract with you

This Evidence of Coverage is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The benefits described in this Evidence of Coverage are in effect during the months listed on the first page, as long as you are a validly enrolled member in this plan.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

2. What makes you eligible to be a plan member?

2.1 **Your eligibility requirements**

You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
 - and you are entitled to Medicare Part A
 - and you are enrolled in Medicare Part B
 - and you do *not* have End Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
 - You are eligible for coverage under your (or your spouse's) current or former employer's group health plan retiree benefits.

If you have questions regarding your eligibility for coverage under your (or your spouse's) current or former employer's retiree benefits, please contact the employer's benefit administrator.

2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

2.3 Here is the service area for our plan

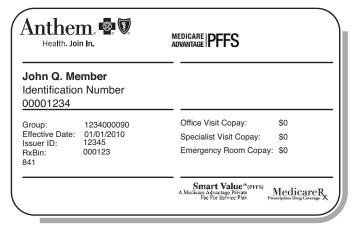
Although Medicare is a federal program, our plan is available only to individuals who live in our geographic service area. To stay a member of our plan, you must keep living in this service area. However, in certain situations, employer groups are allowed to cover their out of state retirees under this plan.

If you are not sure whether you live in the service area, or if you plan to move out of the service area, please contact Customer Service.

3. What other materials will you get from us?

Your plan membership card — Use it to get all covered care and prescription drugs

While you are a member of this plan, you must use your membership card whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:





As long as you are a member of our plan **you must <u>not</u> use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

The Pharmacy Directory: your guide to pharmacies in our network

What are "network pharmacies"?

Our Pharmacy Directory gives you a complete list of network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for plan members.

Why do you need to know about network pharmacies?

You can use the Pharmacy Directory to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

We will send you a complete Pharmacy Directory **at least once every three years.** Every year that you don't get a new Pharmacy Directory, we'll send you a booklet that shows changes to the directory.

If you don't have the Pharmacy Directory, you can get a copy from Customer Service (phone numbers are listed on the front cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network.

3.3 | The plan's List of Covered Drugs (Formulary)

The plan has a List of Covered Drugs (Formulary). We call it the "Drug List." It tells which Part D prescription drugs are covered by our plan. The drugs on this list are selected by us with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can call Customer Service (phone numbers are listed on the front cover of this booklet).

Reports with a summary of payments made for your prescription drugs

When you use your prescription drug benefits, we will send you a report to help you understand and keep track of payments for your prescription drugs. This summary report is called the Explanation of Benefits.

The Explanation of Benefits tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. Chapter 6 (What you pay for your Part D prescription drugs) gives more information about the Explanation of Benefits and how it can help you keep track of your drug coverage.

An Explanation of Benefits summary is also available upon request. To get a copy, please contact Customer Service.

4. Your monthly premium

4.1 | How much is your plan premium?

Your coverage is provided through a contract with your current employer or former employer or union. Please contact your (or your spouse's) current or former employer's benefit administrator to get information on any plan premium amounts for which you may be responsible.

In some situations, you might qualify for help paying your plan premium

There are programs to help people with limited resources pay for their drugs. Chapter 2, tells more about these programs. If you qualify for one of these programs, enrolling in the program might make your monthly plan premium lower.

If you are already enrolled and getting Extra Help from one of these programs, some of the payment information in this Evidence of Coverage may not apply to you. You will be mailed the "Evidence of Coverage Rider for those who Receive Extra Help for the Prescription Drugs" (LIS Rider), that tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Service are listed on the front cover of this booklet. Or, if you are a member of a State Pharmacy Assistance Program (SPAP) and they are helping with your premium costs, please contact your SPAP to determine what help is available to you. For contact information, please refer to the state specific agency listing located in the back of this booklet.

Section (con't)

Chapter

1.

Because you are enrolled in an employer sponsored plan, we will credit the amount of Extra Help received to your prior employer's bill on your behalf. If your employer pays 100% of the premium for your retiree coverage, then they are entitled to keep these funds. However, if you contribute to the premium, your former employer must apply the subsidy toward the amount you contribute to this plan.

In some situations, your plan premium could include a penalty charge each month

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't keep credible drug coverage (as good as Medicare's Part D coverage). For these members, the monthly late enrollment penalty amount is added to the plan's monthly premium. For members on employer sponsored plans this amount is usually added to the premium charged to the employer, unless you are normally billed directly by your plan.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 10 explains the late enrollment penalty.

If you think that you may have a late enrollment penalty, you may want to contact your (or your spouse's) former employer's benefit administrator to find out what you will have to pay towards the penalty. Or, if you are billed directly by our plan, please contact Customer Service (phone numbers are listed on the front cover of this booklet).

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B.

- Your copy of *Medicare & You 2010* tells about these premiums in the section called "2010 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2010* from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

4.2

Chapter

Can we change your monthly plan premium during the year?

Generally, your plan premium won't change during the benefit year. We will tell you in advance if there will be any changes for the next benefit year in your plan's premiums or in the amounts you will have to pay when you get your prescriptions covered.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay part of the member's monthly plan premium. A member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. A member who loses their eligibility during the year will need to start paying their full monthly premium.

You can find out more about Extra Help in Chapter 2, Section 7.

What if you believe you have qualified for "Extra Help"?

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

Please fax or mail a copy of your paperwork showing you qualify for subsidy. Below are examples of what paperwork you can provide:

Proof of LIS Status

- A copy of a member's Medicaid card that includes the member's name and the eligibility date during the discrepant period.
- A copy of a letter from the State or SSA showing Medicare Low-Income Subsidy status.
- The date that a verification call was made to the State Medicaid Agency, the name and telephone number of the state staff person who verified the Medicaid period, and the Medicaid eligibility dates confirmed on the call.
- A copy of a state document that confirms active Medicaid status during the discrepant period.
- A screen-print from the State's Medicaid systems showing Medicaid status during the discrepant period; or

Section (con't)

Chapter

- evidence at point-of-sale of recent Medicaid billing and payment in the pharmacy's patient profile, backed up by one of the above indicators post point-of-sale.
- A print out from the State electronic enrollment file showing Medicaid status during the discrepant period.

Proof of Institutional Status for a Full-Benefit Dual Eligible

- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period.
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- a screen print from the State's Medicaid systems showing that individual's
 institutional status based on at least a full calendar month stay for Medicaid
 payment purposes during the discrepant period.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service (phone numbers are listed on the front cover of this booklet) if you have questions.

5. Please keep your plan membership record up to date

5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

Doctors, hospitals, pharmacists, and other providers need to have correct information about you. **These providers use your membership record to know what services and drugs are covered for you.** Because of this, it is very important that you help us keep your information up to date.

Chapter

1.

Call Customer Service to let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan.

Once each year, we will send you a letter that lists any other medical and or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are listed on the front cover of this booklet).

2.

Important phone numbers and resources

Section	Contents	Page
1.	How to contact us, including how to reach Customer Service at the plan	12
2.	Medicare (how to get help and information directly from the Federal Medicare program)	13
3.	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)	14
4.	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)	15
5.	Social Security	15
6.	Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources)	16
7.	Information about programs to help people pay for their prescription drugs	16
8.	How to contact the Railroad Retirement Board	17
9.	Do you have "group insurance" or other health insurance from another employer?	18

Page 12

Section

1.

How to contact us, including how to reach Customer Service at the plan

For assistance with claims, billing or member card questions, please call or write to Anthem SmartValue Customer Service. We will be happy to help you.

Customer Service

Call 1-877-326-2201

8 a.m. to 9 p.m., 7 days a week. Calls to this number are free.

TTY 1-800-425-5705

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Write Anthem SmartValue

P.O. Box 110

Fond du Lac, Wisconsin 54936

Website www.anthem.com/medicare

How to contact us when you are asking for a coverage decision or making an appeal, or compliant about your medical care or Part D prescription drugs

You may call us if you have questions about our coverage decision process.

Coverage Decisions, Appeals, or Complaints

Call 1-877-326-2201

Calls to this number are free.

TTY 1-800-425-5705

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Fax 1-877-811-5116

Write Anthem SmartValue

P.O. Box 1975

Fond du Lac, Wisconsin 54936

For more information on asking for coverage decisions, appeals or complaints about your medical care or Part D prescription drugs, see Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

2.

Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (Asking the plan to pay its share of a bill you have received for medical services or drugs).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints) for more information.

Payment Requests

Call 1-877-326-2201

Calls to this number are free.

TTY 1-800-425-5705

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Fax 1-877-811-5116

Write Anthem SmartValue

P.O. Box 110

Fond du Lac, Wisconsin 54936

Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage Organizations including us.

Medicare

Call 1-800-MEDICARE, or 1-800-633-4227

Calls to this number are free. 24 hours a day, 7 days a week.

TTY 1-877-486-2048

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free.

Website <u>www.medicare.gov</u>

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites."

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. It is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. They can also help you understand your Medicare plan choices and answer questions about switching plans.

For contact information, please refer to the state specific agency listing located in the back of this booklet. You may also find the Website for your local SHIP at www.medicare.gov on the Web. Under "Search Tools," select "Helpful Phone Numbers and Websites."

Chapter

2.

Quality Improvement Organization (paid by Medicareto check on the quality of care for people with Medicare)

There is a Quality Improvement Organization (QIO) in each state. QIOs have different names depending on which state they are in.

QIO has a group of doctors and other health care professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. It is an independent organization and is not connected with our plan.

You should contact QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You made a complaint to our plan and you don't like our response to your complaint.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

For contact information, please refer to the state specific agency listing located in the back of this booklet.

5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare and pay the Part B premium. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security Administration

Call 1-800-772-1213

Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use the automated telephone services to get recorded information and conduct some business 24 hours a day.

6.

TTY 1-800-325-0778

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.

Website www.ssa.gov

Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact your local Medicaid office in your area.

For contact information, please refer to the state specific agency listing located in the back of this booklet

Information about programs to help people pay for their prescription drugs

7.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

If you qualify for Extra Help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" (LIS Rider) that explains your costs as a member of this plan. If the amount of your Extra Help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their prescription Drugs" (LIS Rider).

If you think you may qualify for Extra Help, call Social Security (see the state specific agency listing located in the back of this booklet for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see the state specific agency listing located in the back of this booklet for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs (SPAP) that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

The State Pharmaceutical Assistance Program is a state organization that provides limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. For contact information, please refer to the state specific agency listing located in the back of this booklet.

8. How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board

Call 1-877-772-5772

Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY 1-312-751-4701

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are not free.

Website <u>www.rrb.gov</u>

9.

Do you have "group insurance" or other health insurance from another employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Chapter

Page 19

2010 Evidence of Coverage for Anthem SmartValue Using the plan's coverage for your medical services 3.

Section	Contents	Page
1.	Things to know about getting your medical care as a member of our plan	20
1.1	What are "providers and covered services"?	20
1.2	Basic rules for getting your medical care that is covered by our plan	20
2.	How to get covered services when you have an emergency	22
2.1	Getting care if you have a medical emergency	22
3.	What if you are billed directly for the full cost of your covered services?	23
3.1	You can ask the plan to pay our share of the cost of your covered services	23
3.2	If services are not covered by our plan, you must pay the full cost	23
4.	How are your medical services covered when you are in a "clinical research study"?	24
4.1	What is a "clinical research study"?	24
4.2	When you participate in a clinical research study, who pays for what?	25
5.	Rules for getting care in a "religious non-medical health care institution"	26
5.1	What is a religious non-medical health care institution?	26
5.2	What care from a religious non-medical health care institution is covered by our plan?	26
6.	Information about hospice care	27
6.1	What is hospice care?	27
6.2	How do you get hospice care if you are terminally ill?	27
6.3	How is your hospice care paid for?	27
7.	Information about organ transplants	27
7.1	How to get an organ transplant if you need it.	27

2010 Evidence of Coverage for Anthem SmartValue
Using the plan's coverage for your medical services

Page 20

Section

1.

Chapter

3.

Things to know about getting your medical care as a member of our plan

This chapter tells you what you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay as your share of the cost when you get this care, use the Benefit Chart located in the front of this booklet and Chapter 4 (What is covered and what you pay).

1.1 What are providers and covered services?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- "Providers" are doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities. Our plan may cover additional supplemental benefits such as dental, hearing and vision. Please review the Benefit Chart located in the front of this booklet to see if you have coverage for these benefits. These benefits are typically located under the "Additional Benefits" section of the Benefit Chart. Although these benefits do not require you to see a network provider your cost-sharing will usually be lower if you receive these services from a network provider. (Definition of a Network Provider is located in Chapter 12).
- "Covered services" include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Benefit Chart located in the front of this booklet.

Basic rules for getting your medical care that is covered by the plan

Our plan will generally cover your medical care as long as:

- The care you receive is included in the plan's Medical Benefit Chart (this chart is located in the front of this booklet).
- The care you receive is considered medically necessary. It needs to be an accepted treatment for your medical condition.
- You can receive your care from any provider in the United States, if the
 provider is eligible to be paid by Medicare and agrees to accept our plan's
 terms and conditions of payment prior to providing services to you and is eligible
 to provide services under Medicare.

Chapter

3.

- A provider is considered to have agreed to accept the terms and conditions of payment if the provider was aware that you are a member of the PFFS plan before providing services to you (for example: if you showed them your PFFS plan card); the provider had reasonable access to our terms and conditions of payment; and the provider provided covered services to you. The provider doesn't have to actually read the terms and conditions of payment. Rather if he or she had the opportunity to read them and he or she treats you, the law deems this provider as if he or she had signed a contract.
 - You must show your plan membership card every time you visit a provider.
 A provider can decide at every visit to accept our plan's terms and conditions, and thus treat you. A provider cannot change his/her mind about accepting the terms and conditions of payment after providing services.
 - Not all providers accept our plan's terms and conditions of payment or agree to treat you. If a provider from whom you seek care decides not to accept our plan's terms and conditions of payment or refuses to treat you, then you will need to find another provider that will accept our plan's terms and conditions of payment. A provider that decides not to accept our plan's terms and conditions of payment should not provide services to you, except in emergencies. You may contact Customer Service for assistance locating another provider in your area who will accept our plan's terms and conditions of payment. See Chapter 2 for information about how to contact Customer Service.
 - If you need emergency care, it is covered whether a provider agrees to accept the plan's payment terms or not.
- You are required to pay only the copayment or coinsurance amount allowed by our plan at the time of the visit. You should ask the provider to bill the plan for your covered services. If the provider asks you to pay the full amount of the services, and have you paid back by the plan, remind the provider that you are only responsible for the cost-sharing amount. If the provider wants further information on payment for covered services, please have the provider contact Customer Service, (phone numbers are listed on the front cover of this booklet).

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: www.anthem.com/medicare.

2.

How to get covered services when you have an emergency

2.1 | Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do not need to get approval from our plan.
- As soon as possible, notify us of your emergency by calling Customer Service (phone numbers are listed on the front cover of this booklet).

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it anywhere in the United States. Please refer to the Benefit Chart, located in the front of this booklet to see if our plan offers international emergency coverage. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the medical Benefit Chart located in the front of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

If you decide to get follow-up care from the provider treating you, then you should advise them of your plan enrollment as soon as possible, by showing them your membership ID card. The plan will pay for all medically-necessary plan-covered services furnished by the provider and non-emergency care that you get from any provider in the United States who agrees to accept our plan's terms and conditions of payment.

3.

What if you are billed directly for the full cost of your covered services?

You can ask the plan to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for payments you have already made.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (Asking the plan to pay its share of a bill you have received for medical services or drugs) for information about what to do.

If services are not covered by our plan, you must pay the full cost

This plan covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (What to do if you have a problem or complaint) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service at the number listed on the front cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. These costs will not count toward your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

4.

How are your medical services covered when you are in a "clinical research study"?

4.1 What is a "clinical research study"?

A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from our plan or your Primary Care Physician.

Although you do not need to get our permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

- 1. We can let you know whether the clinical research study is Medicare-approved.
- 2. We can tell you what services you will get from clinical research study providers instead of from our plan.
- 3. We can keep track of the health care services that you receive as part of the study.

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are listed on the front cover of this booklet).

Chapter

4.2

When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, **Medicare will pay for the covered services you receive as part of the research study.** Medicare pays for routine costs of items and services. Examples of these items and services include the following:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

When you are part of a clinical research study, **Medicare will not pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive as a participant in the clinical research study. Because you are a member of this plan, you *do not* have to pay the deductibles for Original Medicare Part A or Part B.

Do you want to know more?

To find out what your coinsurance would be if you joined a Medicare-approved clinical research study, please call Customer Service (phone numbers are listed on the front cover of this booklet).

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (**www.medicare.gov**). You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

5.

5.2

Rules for getting care in a "religious non-medical health care institution"

5.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, you must elect to have your coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is not voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care
 - \circ and you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

6. Information about hospice care

6.1 What is hospice care?

"Hospice" is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

6.2 | How do you get hospice care if you are terminally ill?

As a member of our plan, you may receive care from any Medicare-certified hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Customer Service to get a list of the Medicare-certified hospice providers in your area or you may call the Regional Home Health Intermediary at 1-800-633-4227. To get more information, visit www.medicare.gov on the Web. Under "Search Tools," "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

6.3 | How is your hospice care paid for?

If you enroll in a Medicare-certified hospice program, the Original Medicare Plan (rather than this plan) will pay the hospice provider for the services you receive. Even if you choose to enroll in a Medicare-certified hospice, you will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our plan.

7. Organ transplants

7.1 How to get an organ transplant if you need it

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others aren't). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, kidney-pancreatic,

Chapter 3.

2010 Evidence of Coverage for Anthem SmartValue Using the plan's coverage for your medical services

Page 28

Section (con't)

liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. The following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

When it is determined a transplant may be needed we strongly encourage you to pre-notify our plan by calling the Customer Service number on the back of your Identification Card and ask to speak with a Transplant Coordinator. Although certain transplants are covered; you must meet specific medical criteria for benefit coverage and the transplant must be performed in an approved facility. The Transplant Coordinator will help you in determining whether the proposed transplant is a covered benefit and that you have met all the requirements. The Transplant Coordinator will also advocate on your behalf with your transplant team to assure your best outcome.

Chapter

Page 29

2010 Evidence of Coverage for Anthem SmartValue
Medical benefits
(What is covered and what you pay)

Section	Contents	Page
1.	Understanding your out-of-pocket costs for covered services	30
1.1	What types of out-of-pocket costs do you pay for your covered services?	30
1.2	What is the maximum amount you will pay for certain covered medical services?	30
2.	Use the Medical Benefit Chart located in the front of this booklet, along with this chapter to find out what is covered for you and how much you will pay	31
2.1	Your medical benefits and costs as a member of the plan	31
3.	What types of benefits are not covered by the plan?	31
3 1	Types of henefits we do not cover (exclusions)	31

1.

4.

Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. The Medical Benefit Chart located in the front of this booklet gives a list of your covered services and tells how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered and limitations on certain services.

Page

30

What types of out-of-pocket costs do you pay for your 1.1 covered services?

To understand the information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The "deductible" means the amount you must pay for medical services before our plan begins to pay its share.
- A "copayment" means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- "Coinsurance" means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.

Some people qualify for programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in these programs, you may still have to pay the Medicaid copayment, depending on the rules in your state.

What is the maximum amount you will pay for certain 1.2 covered medical services?

There is a limit to how much you have to pay out-of-pocket for certain covered health care services each year. After this level is reached, you will have 100% coverage and not have to pay any out of pocket costs for the remainder of the year for covered services. Please refer to the Benefit Chart located in the front of this booklet for what services and amounts are included in the out of pocket maximum.

Page 31

Section

2.

3.

Use the Medical Benefit Chart located in the front of this booklet, to find out what is covered for you and how much you will pay

Your medical benefits and costs as a member of the plan

The medical Benefit Chart located in the front of this booklet, lists the services our plan covers and what you pay for each service. The services listed in the Medical Benefit Chart are covered only when all coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventive services and screening tests, your services
 (including medical care, services, supplies, and equipment) must be medically
 necessary. Medically necessary means that the services are an accepted treatment
 for your medical condition.
- You may receive plan-covered services from any provider who agrees to accept the terms and conditions of payment of our plan. A provider is considered to have agreed to accept the terms and conditions of payment if they knew you were a member of the PFFS plan (for example if you showed them your PFFS plan card) and they had the opportunity to read the terms and conditions of payment. The provider doesn't have to actually read the terms and conditions of payment. Rather if he or she had the opportunity to read them then as soon as he or she treats you, the law deems this provider as if he or she had signed a contract.

What types of benefits are not covered by the plan?

Types of benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception is if a benefit on the exclusion list is found upon

appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefit Chart, or anywhere else in this *Evidence of Coverage*, the following items and services aren't covered except as indicated by our plan:

- 1. Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- 2. Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 3 for more information on clinical research studies.
- 3. Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- 4. Private room in a hospital, except when it is considered medically necessary.
- 5. Private duty nurses.
- 6. Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- 7. Full-time nursing care in your home.
- 8. Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing, walking, getting in and out of bed, dressing, eating, using the restroom, preparation of special diets and supervision of medication that is usually self-administered.
- 9. Homemaker services which provide basic household assistance, including light housekeeping or light meal preparation.
- 10. Fees charged by your immediate relatives or members of your household.
- 11. Meals delivered to your home.
- 12. Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- 13. Cosmetic surgery or procedures unless needed because of an accidental injury or to improve a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Chapter

4.

- 14. Routine dental care, such as cleanings, fillings or dentures unless specified otherwise in the Benefit Chart. However, non-routine dental care received at a hospital may be covered.
- 15. Unless specified otherwise in the Benefit Chart, chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- 16. Unless specified otherwise in the Benefit Chart, routine foot care, except for the limited coverage provided according to Medicare guidelines.
- 17. Unless specified otherwise in the Benefit Chart, Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- 18. Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- 19. Unless specified otherwise in the Benefit Chart, hearing aids and routine hearing examinations.
- 20. Unless specified otherwise in the Benefit Chart, eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- 21. Unless specified otherwise in the Benefit Chart, prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
- 22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- 23. Unless specified otherwise in the Benefit Chart, acupuncture.
- 24. Naturopath services (uses natural or alternative treatments).
- 25. Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- 26. Benefits to the extent that they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Evidence of Coverage will be coordinated with such governmental units to the extent required under existing state or federal laws.
- 27. Services for illness or injury that occur as a result of any act of war, declared or undeclared if care is received in a governmental facility.
- 28. Services for court-ordered testing or care unless medically necessary and authorized by our plan.

- 29. Services for which you have no legal obligation to pay in the absence of this or like coverage.
- 30. Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- 31. Charges in excess of the maximum allowable amount, unless otherwise specified in this Evidence of Coverage.
- 32. Charges for completion of claim forms or charges for medical records or reports unless otherwise required by law.
- 33. Charges for missed or canceled appointments.
- 34. Charges for services incurred prior to your effective date.
- 35. Charges for services incurred after the termination date of this coverage, except as specified elsewhere in this Evidence of Coverage.
- 36. Services or supplies primarily for educational, vocational or training purposes, except at otherwise specified in this Evidence of Coverage.
- 37. For self-help training and other forms of non-medical self-care, except as otherwise provided in this Evidence of Coverage.
- 38. Services that are not covered by Medicare.
- 39. Any services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Chapter

Page 35

5.

2010 Evidence of Coverage for Anthem SmartValue Using your plan's coverage for your Part D prescription drugs

Section	Contents	Page
1.	Introduction	37
1.1	This chapter describes your coverage for Part D drugs	37
1.2	Basic rules for the plan's Part D drug coverage	38
2.	Fill your prescription at a network pharmacy or through the plan's mail-order service	38
2.1	To have your prescription covered, use a network pharmacy	38
2.2	Finding network pharmacies	39
2.3	Using the plan's mail-order services	40
2.4	How can you get a long-term supply of drugs?	40
2.5	When can you use a pharmacy that is not in the plan's network?	41
3.	If you have a Closed Formulary Plan, your drugs need to be on the plan's "Drug List"	41
3.1	The "Drug List" tells which Part D drugs are covered	41
3.2	How do "cost-sharing tiers" for drugs on the Drug List impact my cost?	42
3.3	How can you find out if a specific drug is on the Drug List?	42
4.	There are restrictions on coverage for some drugs	43
4.1	Why do some drugs have restrictions?	43
4.2	What kinds of restrictions?	43
4.3	Do any of these restrictions apply to your drugs?	44
5.	What if one of your drugs is not covered in the way you'd like it to be covered?	44
5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered	44
5.2	What can you do if your drug is restricted in some way?	45
5.3	What can you do if your drug is in a cost-sharing tier you think is too high?	46

Chapter

Page 36

5.

2010 Evidence of Coverage for Anthem SmartValue Using your plan's coverage for your Part D prescription drugs (con't)

Section	Contents	Page
6.	What if your coverage changes for one of your drugs?	. 47
6.1	The Drug List can change during the year	. 47
6.2	What happens if coverage changes for a drug you are taking?	. 47
7.	What types of drugs are <i>not</i> covered by the plan?	. 48
7.1	Types of drugs we do not cover	. 48
8.	Show your plan membership card when you fill a prescription	. 50
8.1	Show your membership card	. 50
8.2	What if you don't have your membership card with you?	. 50
9.	Part D drug coverage in special situations	. 50
9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?	. 50
9.2	What if you're a resident in a long-term care facility?	. 51
9.3	What if you're also getting drug coverage from another employer or retiree group plan?	. 51
10.	Programs on drug safety and managing medications	. 52
10.1	Programs to help members use drugs safely	. 52
10.2	Programs to help members manage their medications	52

Section Q/A



Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For information on these programs see Chapter 2 and 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in this Evidence of Coverage is not correct for you. If you qualify for Extra Help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a member of this plan. If the amount of your Extra Help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs." If you need a copy of your "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs", please call Customer Service. Phone numbers for Customer Service are listed on the front cover of this booklet.

1. Introduction

1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, What you pay for your Part D prescription drugs).

In addition to your coverage for Part D drugs, our plan also covers some drugs under the plan's medical benefits:

 The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. The Benefit Chart located in the front of this booklet and Chapter 4 tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.

2.

 Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, drug injections you are given during an office visit, drugs you are given at a dialysis facility and drugs you receive via medical equipment such as nebulizers. The Benefit Chart tells about your benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits. **This chapter explains rules for using your coverage for Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, What you pay for your Part D prescription drugs).

1.2 | Basic rules for your plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must use a network pharmacy to fill your prescription. (See Section 3; Fill your prescriptions at a network pharmacy.)
- If the plan has a Closed Formulary (Closed Drug List), your drug must be on the plan's Drug List (See section 3, Your drugs must be on the plan's Drug List).
- If the plan you has an Open Formulary (Open Drug List) you have coverage for additional drugs not in the Drug List. Drugs not listed will be covered unless they are excluded because of safety concerns, statutory restrictions or are typically not covered by drug plan benefits. See the Benefit Chart located in the front of this booklet to find out if you have an Open Formulary plan.
- Your drug must be considered medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be prescribed for an accepted treatment for your medical condition.

Fill your prescription at a network pharmacy or through your plan's mail-order service

$_{2.1}$ To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies.

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by the plan.

2.2

Finding network pharmacies

How do you find a network pharmacy in your area?

You can look in your Pharmacy Directory, or call Customer Service (phone numbers are listed on the front cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to either have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are listed on the front cover of this booklet) or use the Pharmacy Directory.

What if you need a non-retail network pharmacy?

Sometimes prescriptions must be filled at a non-retail network. These pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy.
 Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations, require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate a non-retail network pharmacy, look in your Pharmacy Directory or call Customer Service (phone numbers are listed on the front cover of this booklet)

2.3 Using the plan's mail-order services

Our plan's mail-order service requires you to order up to a 90 day supply for most drugs. Specialty drugs are only available in a 30-day supply on most plans. Please check the Benefit Chart located in the front of this booklet to verify the maximum day supply limits in our plan for mail order drugs.

To get order forms and information about filling your prescriptions by mail please call Customer Service. If you use a mail order pharmacy not in our plan's network, your prescription will not be covered.

Usually a mail order pharmacy order will get to you in no more than 12 days. However, sometimes your mail order may be delayed. If your mail order is delayed, we will notify you and provide instructions on how to obtain your prescription in the interim.

2.4 | How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of "mail-order" drugs on our plan's Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

- 1. **Some retail pharmacies** in our network allow you to get a "longer-term" supply of mail-order drugs. Your Pharmacy Directory tells you which pharmacies in our network can give you a longer-term supply of mail-order drugs. You can also call Customer Service for more information.
 - You are not required to use the mail-order service to get a "longer-term" supply of mail order drugs. If you get a "longer-term" supply of mail order drugs at a retail network pharmacy, your cost-sharing may be different than it is for a "longer-term" supply from the mail-order service. Please check the Benefit Chart located in the front of this booklet to find out what your costs will be if you get a "longer-term" supply from a retail pharmacy. You can also call Customer Service for more information (phone numbers are listed on the front cover of this booklet).
- 2. For "all" kinds of drugs, you can use our plan's network **mail-order services.**Our plan's mail-order service requires you to order up to a 90 day supply for most drugs. Specialty drugs are only available in a 30-day supply on most plans.
 Please check the Benefit Chart located in the front of this booklet to verify the maximum day supply limits in our plan for mail order drugs. See Section 2.3 for more information about using our mail-order services.

3.

2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription might be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Please check first with Customer Service to see if there is a network pharmacy nearby.

We will cover your prescription at a non-network pharmacy if at least one of the following applies:

- You are traveling within the United States and territories and become ill, lose or run out of your prescription drugs.
- The prescription is for a medical emergency or urgent care.
- You are unable to obtain a covered drug in a timely manner within our service area because a network pharmacy that provides 24-hour service is not available within a 25-mile driving distance.
- You are filling a prescription for a covered drug and that particular drug (for example, an orphan drug or other specialty pharmaceutical) is not regularly stocked at an accessible network retail or mail order pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

In addition to paying the copayments/coinsurances listed on the Benefit Chart located in the front of this booklet, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

If you have a Closed Formulary Plan, your drugs need to be on your plan's "Drug List"

3.1 The "Drug List" tells which Part D drugs are covered

Your plan has a "List of Covered Drugs (Formulary)." In this Evidence of Coverage, we call it the "Drug List."

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

The drug list includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brandname drug. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs.

How do "Cost-Sharing Tiers" for drugs on the Drug List impact my costs?

Every drug on our plan's Drug List is in one of the plan's cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug. The types of drugs placed into the cost-sharing tier used by this plan are shown in the Benefit Chart located in the front of this booklet.

To find out which cost-sharing tier your drug is in, please check our plan's *Drug List*.

The amount you pay for drugs in each cost-sharing tier is shown in the Benefit Chart located in the front of this booklet.

3.3 How can you find out if a specific drug is on the Drug List?

You have two ways to find out:

- 1. Check the most recent Drug List we sent you in the mail.
- 2. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are listed on the front cover of this booklet.

4. There are restrictions on coverage for some drugs

4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Using generic drugs whenever you can

A "generic" drug works the same as a brand-name drug, but usually costs less. When a generic version of a brand-name drug is available, our network pharmacies must provide you the generic version. However, if your doctor has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called "prior authorization." Sometimes plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Chapter	2010 Evidence of Coverage for Anthem SmartValue
5.	Using your plan's coverage for your Part D prescription drugs

Page 44

Section

5.

Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are listed on the front cover of this booklet).

What if one of your drugs is not covered in the way you'd like it to be covered?

There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- What if the drug you want to take is not covered by the plan? For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- What if the drug is covered, but there are extra rules or restrictions on coverage for that drug? As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
- What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be? The plan puts each covered drug into one of the different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

5.2

What can you do if your drug is restricted in some way?

If coverage for your drug is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply).
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug in the way you would like it to be covered

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements given below:

1. The change to your drug coverage must be one of the following types of changes:

- If you are on a Closed Formulary plan, the drug you have been taking is **no** longer on the plan's Drug List.
- -or- for all plans, the drug you have been taking is **now restricted in some** way (Section 4.2 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- For those members who were in the plan last year:

 We will cover a temporary supply of your drug one time only during
 the first 90 days of the benefit year. This temporary supply will be for a
 maximum of a 30-day supply, or less if your prescription is written for fewer
 days. The prescription must be filled at a network pharmacy.
- For those members who are new to this plan and aren't in a long-term care facility:

We will cover a temporary supply of your drug **one time only during the first** *90 days* **of your membership** in the plan. This temporary supply will be for a maximum of a *30-day supply*, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

• For those who are new members, and are residents in a long-termcare facility:

We will cover a temporary supply of your drug during the first 90 days of your membership in this plan. The first supply will be for a maximum of a 34-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in this plan.

5.3

• For those who have been a member of this plan for more than 90 days and you are a resident of a long-term care facility and need a supply right away:

We will cover one *34-day supply* or less if your prescription is written for fewer days. This is in addition to the above LTC transition supply.

To ask for a temporary supply, call Customer Service (phone numbers are listed on the front cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your provider or other prescriber can help you request an exception to the rule.

For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your doctor or other prescriber want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. If your doctor or other provider says that you have medical reasons that justify asking us for an exception, your doctor can help you request an exception to the rule.

If you and your doctor want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

6. What if your coverage changes for one of your drugs?

6.1 | The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- Add or remove drugs from the Drug List. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 4 in this chapter).
- Replace a brand-name drug with a generic drug.

In almost all cases, we must get approval from Medicare for any changes we make to the plan's Drug List.

6.2 What happens if coverage changes for a drug you are taking? How will you find out if your drug's coverage has been changed?

If there is a change to coverage for a drug you are taking, the plan will send you a notice to tell you. Normally, we will let you know at least 60 days ahead of time.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the drug list. We will let you know of this change right away. Your doctor will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because
 of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a brand-name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
 - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
 - Or you and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9 (What to do if you have a problem or complaint).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your doctor will also know about this change, and can work with you to find another drug for your condition.

7. What types of drugs are not covered by the plan?

7.1 | Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." "Excluded" means that the plan doesn't cover these types of drugs because the law doesn't allow any Medicare drug plan to cover them.

If you get drugs that are excluded, you must pay for them yourself or they may be covered under the medical part of our plan.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration
 - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law these categories of drugs are not covered by Medicare drug plans unless our plan covers them as 'Extra Covered Drug Groups'. Please see the 'Extra Covered Drug Groups' section of the Benefit Chart located in the front of this booklet to find out which of the drugs listed below are covered under the plan you have.:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

If you have coverage for some prescription drugs not normally covered in a Medicare Prescription Drug Plan, shown in the "Extra Covered Drug Groups" section of the Benefit Chart located in the front of this booklet, the amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this booklet.)

8.

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help will not pay for the drugs not normally covered. (Please refer to your Drug List or call Customer Service for more information.) However, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. For contact information, please refer to the state specific agency listing located in the back of this booklet.

Show your plan membership card when you fill a prescription

8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. (You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

9. Part D drug coverage in special situations

What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 10, Ending your membership in the plan, tells you when you can leave our plan and join a different Medicare plan.)

9.2 What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your Pharmacy Directory to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service (phone numbers are listed on the front cover of this booklet).

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on your Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of a 34-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on your Drug List or if the plan has any restriction on the drug's coverage, we will cover one 34-day supply or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, Chapter 9, Section 6.2 tells you what to do.

9.3 What if you're also getting drug coverage from another employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

Programs on drug safety and managing medications **10**.

10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Programs to help members manage their medications 10.2

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

6.

2010 Evidence of Coverage for Anthem SmartValue What you pay for your Part D prescription drugs

Section	Contents	Page
1.	Introduction	55
1.1	Use this chapter together with other materials that explain your drug coverage	55
2.	What you pay for a drug depends on which "drug coverage stage" you are in when you get the drug	56
2.1	What are the drug coverage stages?	56
3.	We send you reports that explain payments for your drugs and which coverage stage you are in	57
3.1	We send you a monthly report called the "Explanation of Benefits"	57
3.2	Help us keep our information about your drug payments up to date	58
4.	During the Deductible Stage, you pay the full cost of your drugs	58
4.1	You stay in the Deductible Stage until you have paid the amount listed in your Benefit Chart for your drugs	58
5.	During the Initial Coverage Stage, your plan pays its share of your drug costs and you pay your share	59
5.1	What you pay for a drug depends on the drug and where you fill your prescription	59
5.2	When does the Initial Coverage Stage end?	60
6.	If this plan has a Coverage Gap Stage, your costs will change after you reach the Initial Coverage Limit	60
6.1	You can look at the Benefit Chart located in the front of this booklet to find out if your plan has a Coverage Gap Stage	60
6.2	How Medicare calculates your out-of-pocket costs for prescription drugs	61

Chapter 6. 2010 Evidence of Coverage for Anthem SmartValue What you pay for your Part D prescription drugs (con't)

Section	Contents	Page
7.	During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs	62
7.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the benefit year	62
8.	Additional benefits information	63
8.1	Our plan offers additional benefits	63
9.	What you pay for vaccinations depends on how and where you get them	63
9.1	Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot	63
9.2	You may want to call us at Customer Service before you get a vaccination	65
10.	Do you have to pay the Part D "late enrollment penalty"?	65
10.1	What is the Part D "late enrollment penalty"?	65
10.2	How much is the Part D late enrollment penalty?	66
10.3	In some situations, you can enroll late and not have to pay the penalty	67
10.4	What can you do if you disagree about your late enrollment penalty?	67

Section Q/A



Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. The "Extra Help" program helps people with limited resources pay for their drugs. For more information, see Chapter 2 Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in this *Evidence of Coverage* is may not apply to you. You will be mailed the 'Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" (LIS Rider) that tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" (LIS Rider). Phone numbers for Customer Service are listed on the front cover of this booklet.

1. Introduction

1.1

Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5 some drugs are covered under Original Medicare or are excluded under law. Some excluded drugs may be covered by this plan. To find out which "Extra Covered Drug Groups" are covered by this plan, please look at the Benefit Chart located in the front of this booklet.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

• The plan's List of Covered Drugs (Formulary). To keep things simple, we call this the "Drug List."

2.

- This Drug List tells which drugs are covered for you.
- It also tells which of the "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
- If you need a copy of the Drug List, call Customer Service (phone numbers are listed on the front cover of this booklet).
- Chapter 5 of this booklet. Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- The plan's Pharmacy Directory. In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The Pharmacy Directory has a list of pharmacies in the plan's network and it tells how you can use the plan's mail-order service. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three months supply).

What you pay for a drug depends on which "drug coverage stage" you are in when you get the drug

2.1 What are the drug coverage stages?

As shown in the table below, there are 4 "drug coverage stages" that may be used in this plan. The drug coverage stages used in this plan are shown in the Benefit Chart located at the front of this booklet. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1	Stage 2	Stage 3	Stage 4 Catastrophic Coverage Stage
Yearly Deductible	Initial Coverage	Coverage Gap	
Stage	Stage	Stage	
If the plan has a deductible stage, you begin in this stage when you fill your first prescription of the year.	The plan pays its share of the cost of your drugs and you pay your share of the cost.	If the plan provides the same Initial Coverage until you reach your True Out of Pocket, you do not have a coverage gap stage. The Benefit Chart located in the front of this booklet will not have a 'Gap Coverage' section.	Once you have paid enough for your drugs to move on to this last stage, the plan will pay most of the cost of your drugs for the rest of the year.

(continued on next page)

Chapter

Section (con't)

3.

3.1

Stage 1	Stage 2	Stage 3	Stage 4 Catastrophic Coverage Stage
Yearly Deductible	Initial Coverage	Coverage Gap	
Stage	Stage	Stage	
During this stage you pay the full cost of your drugs. You stay in this stage until you have paid the deductible amount shown in the Benefit Chart located in the front of this booklet.	You stay in this stage until your payments for the year plus the plan's payments total the amount shown on the Benefit Chart located in the front of this booklet.	If the plan provides different coverage once the Initial Coverage limit is reached, the Benefit Chart located in the front of this booklet will include a 'Gap Coverage' Stage.	The amount you pay for drugs in the Catastrophic Stage is shown in the Benefit Chart located in the front of this booklet.

We send you reports that explain payments for your drugs and which coverage stage you are in

We send you a monthly report called the "Explanation of Benefits"

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug coverage stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "out-of-pocket" cost.
- We keep track of your "total drug costs." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the Explanation of Benefits (it is sometimes called the "EOB") when you have had one or more prescriptions filled. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- Totals for the benefit year used by your group plan (see dates on the first page of this booklet). This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the benefit year began.

4.

6.

Help us keep our information about your drug payments 3.2 up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- Show your membership card when you get a prescription filled. To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- Make sure we have the information we need. There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- Check the written report we send you. When you receive an Explanation of Benefits in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Customer Service (phone numbers are listed on the front cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

During the Deductible Stage, you pay the full cost of your drugs

You stay in the Deductible Stage until you have paid the 4.1 amount listed in your Benefit Chart for your drugs

If the plan has a Deductible Stage, this stage is the first coverage stage for your drug coverage. This stage begins when you fill your first prescription in the benefit year.

5.

5.1

When you are in this coverage stage, you must pay the full cost of your drugs until you reach the plan's deductible amount.

- Your "full cost" is usually lower than the normal full price of your drug, since our plan has negotiated lower costs for most drugs.
- The "deductible" is the amount you must pay for your Part D prescription drugs before our plan begins to pay its share.

If the plan has a deductible, once you have paid the deductible amount for your drugs, you move on to the next drug coverage stage, which is the Initial Coverage Stage. If the plan does not have a deductible, you begin in the Initial Coverage Stage.

During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, your plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has Cost-Sharing Tiers

Every drug on the plan's Drug List is in one of it's cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

To find out what copayment or coinsurance you will pay for drugs in each cost-sharing tier, please see the Benefit Chart located in the front of this booklet.

To find out which cost-sharing tier your drug is in, please check the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in the plan's network
- Our plan's mail order pharmacy
- A pharmacy that is not in the plan's network

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and our plan's Pharmacy Directory.

6.

Chapter

6.

5.2 | When does the Initial Coverage Stage end?

If the plan provides the same Initial Coverage until you reach your True Out of Pocket amount, the Benefit chart located in the front of this booklet will not show an Initial Coverage Limit amount. The Benefit Chart will show the True Out of Pocket amount.

If this plan provides different coverage once the Initial Coverage limit is reached, the Benefit Chart located in the front of this booklet will show the Initial Coverage Limit amount.

If this plan includes an Initial Coverage Limit, your total drug cost is based on adding together what you have paid and what the plan has paid:

- What you have paid for all the covered drugs you have gotten since you
 started with your first drug purchase of the benefit year. (see Section 6.2 for more
 information about how Medicare calculates your out-of-pocket costs)
 This includes:
 - Any deductible amounts you paid when you were in the Deductible Stage.
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- What your <u>plan</u> has paid as its share of the cost for your drugs during the Initial Coverage Stage.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs.

If this plan has a Coverage Gap Stage, your costs will change after you reach the Initial Coverage Limit

You can look at the Benefit Chart located in the front of this booklet to find out if the plan has a Coverage Gap Stage.

If this plan provides the same Initial Coverage until you reach your True Out of Pocket amount, you do not have a coverage Gap Stage. The Benefit Chart located in the front of this booklet will not have a "Gap Coverage" section.

If this plan provides different coverage once the Initial Coverage Limit is reached, the Benefit Chart located in the front of this booklet will include a "Gap Coverage" section, that shows what you must pay during the Gap Coverage Stage.

Once your total out-of-pocket costs reach the amount shown on the Benefit Chart located in the front of this booklet, you will qualify for catastrophic coverage.

6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments <u>are</u> included in your out-of-pocket costs:

When you add up your out-of-pocket costs, **you** <u>can include</u> the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Deductible Stage (if the plan has this stage).
 - The Initial Coverage Stage.
 - The Coverage Gap Stage. (if the plan has this stage)

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by "Extra Help" from Medicare are also included.

Moving on to the Catastrophic Coverage Stage:

When the amount you (or those paying on your behalf) have paid for covered drugs reaches the true out-of-pocket amount listed in the Benefit Chart located in the front of this booklet, you will move to the Catastophic Coverage Stage.

7.

7.1

Chapter

6.

These payments are **not included** in your out-of-pocket costs:

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay, or others pay on your behalf, for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by insurance plans and government-funded health programs such as TRICARE, the Veteran's Administration, the Indian Health Service, or AIDS Drug Assistance Programs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are listed on the front cover of this booklet).

How can you keep track of your out-of-pocket total?

- We will help you. The Explanation of Benefits report we send to you includes the current amount of your out-of-pocket costs (Section 3 tells about this report).
- Make sure we have the information we need. Section 3 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the benefit year

You qualify for the Catastrophic Coverage Stage when you have reached your out-of-pocket costs for the benefit year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the benefit year selected by your (or your spouse's) current or former employer.

Chapter	2010 Evidence of Coverage for Anthem SmartValue	Page
6.	What you pay for your Part D prescription drugs	63

9.

During this stage, the plan will pay most of the cost for your drugs. You can find your cost-sharing amounts in the Catastrophic Coverage section of the Benefit Chart located in the front of this booklet.

8. Additional benefits information

8.1) Our plan offers additional benefits

We provide additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your Initial Coverage Stage or your out of pocket costs. You can find the additional types of drugs covered by our plan in the 'Extra Covered Drug Groups' section of the Benefit Chart located in the front of this booklet. You can find out which specific drugs are covered by checking your "Drug List".

What you pay for vaccinations depends on how and where you get them

Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage for a number of vaccines. There are two parts to your coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot.** (This is sometimes called the "administration" of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

- **1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the Medical Benefit Chart located in the front of this booklet. And Chapter 4 (What is covered and what you pay).
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's List of Covered Drugs.
- 2. Where you get the vaccine medication.
- 3. Who gives you the vaccination shot?

What you pay at the time you get the vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot. If you have a Deductible or Coverage Gap Stage, you are responsible for all of the costs associated with vaccines (including their administration) during these coverage stages of your benefit.

- Situation 1: You buy the vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)
 - You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and its administration.

Situation 2: You get the vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (Asking the plan to pay its share of a bill you have received for medical services or drugs).
- You will be reimbursed the amount you paid less your normal copayment or coinsurance for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you receive Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.

10.

You will be reimbursed the amount charged by the doctor less any
cost-sharing amount that you need to pay for the administration
of the vaccine, less any difference between the amount the doctor
charges and what we normally pay. (If you are in the Extra Help
program, we will reimburse you for this difference.)

Please note that Part B covers the vaccine and administration for influenza, pneumonia and Hepatitis B injections.

When billing us for a vaccine, please include a bill from the provider with the date of service, the NDC code, the vaccine name and the amount charged. Send the bill to:

Anthem SmartValue

P.O. Box 145613

Cincinnati, OH 45250-5613

We can help you understand the costs associated with vaccines (including administration) available under this plan, especially before you go to your doctor. For more information, please contact Customer Service (phone numbers are listed on the front cover of this booklet).

9.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are listed on the front cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost - including whether the vaccination is covered by Medicare Part D or Part B.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

Do you have to pay the Part D "late enrollment penalty"?

10.1 | What is the Part D "late enrollment penalty"?

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced

a continuous period of 63 days or more when you didn't keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to the monthly premium charged to your (or your spouse's) current or former employer for your coverage. If you think you may have a late enrollment penalty, you should contact your (or your spouse's) current or former employer to see what amount you will have to pay. However, if you are billed directly by our plan for your monthly premium, the late enrollment penalty will be included in the bill you receive from us.

10.2 | How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have credible prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, let's say it is 14 months without coverage, which will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2009, this average premium amount was \$30.36. This amount may change for 2010.
- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents. In the example here it would be 14% times \$30.36, which equals \$4.25, which rounds to \$4.30. This amount would be added to the monthly premium for someone with a late enrollment penalty.

There are three important things to note about this monthly premium penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are <u>under</u> 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for Medicare.

If you are eligible for Medicare and are under 65, any late enrollment penalty you are paying will be eliminated when you attain age 65. After age 65, your late enrollment penalty is based only on the months you do not have coverage after your Age 65 Initial Enrollment Period.

In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this "creditable drug coverage."

 Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is at least as good as Medicare's.
- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days in a row.
- If you didn't receive enough information to know whether or not your previous drug coverage was creditable.
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) – and – you signed up for a Medicare prescription drug plan by December 31, 2006 – and – you have stayed in a Medicare prescription drug plan.
- You are receiving Extra Help from Medicare.

What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Customer Service at the number listed on the front of this booklet to find out more about how to do this.

Chapter

Page 68

7.

2010 Evidence of Coverage for Anthem SmartValue Asking your plan to pay its share of a bill you have received for covered services or drugs

Section	Contents	Page
1.	Situations in which you should ask our plan to pay our share of the cost of your covered services or drugs.	. 69
1.1	If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment	. 69
2.	How to ask us to pay you back or to pay a bill you have received	. 71
2.1	How and where to send us your request for payment	. 71
3.	We will consider your request for payment and say yes or no	. 71
3.1	We check to see whether we should cover the service or drug and how much we owe	. 71
3.2	If we tell you that we will not pay for the medical care or drug, you can make an appeal	
4.	Other situations in which you should save your receipts and send them to this plan	. 72
4.1	In some cases, you should send your receipts to this plan to help us track your out-of-pocket drug costs	. 72

1.

1.1

Situations in which you should ask our plan to pay our share of the cost of your covered services or drugs

If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received emergency care from a provider.

You can receive emergency services from any provider. You are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill us for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a provider sends you a bill you think you should not pay

Providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

Chapter

7.

- Whenever you get a bill from a provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. When you use an out-of-network pharmacy to get a prescription filled.

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

• Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

4. When you pay the full cost for a prescription because you don't have your plan membership card with you.

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

 Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription in other situations.

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's List of Covered Drugs (Formulary); or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (What to do if you have a problem or complaint? coverage decisions, appeals, complaints) has information about how to make an appeal.

2.

3.

How to ask us to pay you back or to pay a bill you have received

2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

Mail your request for payment together with any bills or receipts to us at the appropriate address:

Anthem SmartValue

P.O. Box 110

Fond du Lac, Wisconsin 54936

Please be sure to contact Customer Service if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us. See Chapter 2 for information about how to contact Customer Service.

We will consider your request for payment and say yes or no

3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

4.

If we tell you that we will not pay for the medical care or drug, 3.2 you can make an appeal

If you think we have made a mistake in turning you down for your request for payment, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

Page

For the details on how to make this appeal, go to Chapter 9 of this booklet (What to do if you have a problem or complaint? coverage decisions, appeals, complaints). The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.2 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.6 of Chapter 9.

Other situations in which you should save your receipts and send them to this plan

In some cases, you should send your receipts 4.1 to the plan to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than the plan's price.

If your plan includes stages in which you are responsible for 100% of the drug costs, such as a deductible stage, sometimes you can buy your drug at a network pharmacy for a price that is lower than the plan's price.

Chapter **7.**

Section (con't)

For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside the plan's benefit that offers a lower price.

- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- Please note: If you are in a plan stage in which you are responsible for 100% of the drug costs this plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer.

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- Please note: Because you are getting your drug through the patient assistance program and not through the plan's benefits, the plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

8.

Your rights and responsibilities

Section	Contents	Page
1.	Our plan must honor your rights as a member of the plan	75
1.1	We must provide information in a way that works for you (including languages other then English that are spoken in the plan service area and large print)	75
1.2	We must treat you with fairness and respect at all times	75
1.3	We must ensure that you get timely access to your covered services and prescription drugs	75
1.4	We must protect the privacy of your personal health information	76
1.5	We must give you information about the plan and your covered services	81
1.6 1.7	We must support your right to make decisions about your care You have the right to make complaints and to ask us to reconsider	
1.8	decisions we have made What can you do if you think you are being treated unfairly or your rights are not being respected?	
1.9	How to get more information about your rights	85
2.	You have some responsibilities as a member of the plan	85
2.1	What are your responsibilities?	85

1.

Our plan must honor your rights as a member of the plan

We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area or in large print).

To get information from us in a way that works for you, please call Customer Service (phone numbers are listed on the front cover of this booklet).

Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in large print if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

1.2 We must treat you with fairness and respect at all times

Your plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. For contact information, please refer to the state specific agency listing located in the back of this booklet.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are listed on the front cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

We must ensure that you get timely access to your covered services and drugs

You may seek care from any provider in the United States who is eligible to be paid by Medicare and agrees to accept our plan's terms and conditions of payment. You should always (except possibly in emergencies) show the provider your PFFS plan membership

1.4

card. If the provider treats you, the provider becomes a "deemed provider," meaning that the provider is now bound to abide by our rules even if the provider did not read our terms and conditions of payment. As a plan member, you have the right to get appointments and covered services from providers within a reasonable amount of time.

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are listed on the front cover of this booklet).

HIPAA Notice of Privacy Practices — Effective July 1, 2007

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons and to coroners, funeral directors or medical examiners (about decedents).

PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request.

They can also give you any forms we have that may help you with this process.

Chapter

8.

How We Protect Information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job.

Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us.

You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time.

We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following company: Anthem Blue Cross and Blue Shield.

State Notice of Privacy Practices — Effective July 1, 2007

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, and vision benefits that you may have.

Your Personal Information

We may collect, use and share your non-public personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit. We may collect PI about you from other persons or entities such as doctors, hospitals or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following company: Anthem Blue Cross and Blue Shield.

Chapter

8.

We must give you information about the plan and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are listed on the front cover of this booklet):

- **Information about your plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- Information about our network pharmacies.
 - For example, you have the right to get information from us about the qualifications of the pharmacies in our network.
 - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
 - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are listed on the front cover of this booklet).
- Information about your coverage and rules you must follow in using your coverage.
 - In Chapters 3 and 4 and the Benefit Charts located in the front of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters
 5 and 6 of this booklet plus the plan's List of Covered Drugs (Formulary).
 These chapters, together with the List of Covered Drugs, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are listed on the front cover of this booklet).
- Information about why something is not covered and what you can do about it.
 - If a medical service or Part D drug is not covered for you, or if your coverage
 is restricted in some way, you can ask us for a written explanation. You have
 the right to this explanation even if you received the drug from an out-ofnetwork pharmacy.

1.6

- If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

• To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions** for you if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

1.8

Remember, it is your choice whether you want to fill out an advance directive

(including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the appropriate state-specific agency (such as the State Department of Health). For contact information, please refer to the state specific agency listing located in the back of this booklet.

You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are listed on the front cover of this booklet).

What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights. For contact information, please refer to the state specific agency listing located in the back of this booklet.

2.

Chapter

8.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are listed on the front cover of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to Chapter 2, Section 3. For contact information, please refer to the state specific agency listing located in the back of this booklet.

1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are listed on the front cover of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to Chapter 2, Section 3. For contact information, please refer to the state specific agency listing located in the back of this booklet.
- You can contact Medicare.
 - You can visit the Medicare website (<u>www.medicare.gov</u>) to read or download the publication "Your Medicare Rights & Protections."
 - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have some responsibilities as a member of this plan

2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are listed on the front cover of this booklet). We're here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - The Benefit Chart located in the front of this booklet and Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

Chapter

8.

- The Benefit Chart located in the front of this booklet and Chapters 5 and 6 give the details about your coverage for Part D prescription drugs
- If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us. Please call Customer Service to let us know.
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it.
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
 - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - If you have any questions, be sure to ask. Your doctors and other health care
 providers are supposed to explain things in a way you can understand. If you
 ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe. As a plan member, you are responsible for these payments:
 - You must pay your plan premiums, if any, to your (or your spouse's) current or former employer or union (or, if you are billed directly, you must send your payment to the address listed on your billing statement), to continue being a member of our plan.
 - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost).
 You can find this information listed on the Benefit Chart located in the front of this booklet.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

Chapter

8.

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are listed on the front cover of this booklet). We need to keep your membership record up to date and know how to contact you.
 - If you move *outside* of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - If you move *within* the service area, we still need to know so we can keep your membership record up to date and know how to contact you.
- Call Customer Service for help if you have questions or concerns. We also welcome any suggestions you may have for improving your plan.
 - Phone numbers and calling hours for Customer Service are listed on the front cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

Page 88

2010 Evidence of Coverage for Anthem SmartValue What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section	Contents	Page
BACKO	GROUND	
1.	Introduction	. 91
1.1	What to do if you have a problem or concern	
1.2	What about the legal terms?	
2.	You can get help from government organizations that are not connected with us	. 92
2.1	Where to get more information and personalized assistance	. 92
3.	To deal with your problem, which process should you use	? 93
3.1	Should you use the process for coverage decisions and appeals? Or, Should you use the process for making complaints?	. 93
COVER	RAGE DECISIONS AND APPEALS	
4.	A guide to the basics of coverage decisions and appeals	93
4.1	Asking for coverage decisions and making appeals: the big picture	. 93
4.2	How to get help when you are asking for a coverage decision or making an appeal	. 94
4.3	Which section of this chapter gives the details for <u>your</u> situation?	. 95
5.	Your medical care: How to ask for a coverage decision or make an appeal	. 96
5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care	
5.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)	. 98
5.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)	. 101
5.4	Step-by-step: How to make a Level 2 Appeal	. 103

Chapter

Page 89

9.

2010 Evidence of Coverage for Anthem SmartValue What to do if you have a problem or complaint (coverage decisions, appeals, complaints) (con (con't)

Section	Contents	Page
5.5	What if you are asking our plan to pay you for our share of a bill you have received for medical care?	. 105
6.	Your Part D prescription drugs: How to ask for a coverage decision or make an appeal	. 107
6.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug	. 107
6.2	What is an exception?	. 109
6.3	Important things to know about asking for exceptions	. 110
6.4	Step-by-step: How to ask for a coverage decision, including an exception	. 111
6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by your plan)	. 113
6.6	Step-by-step: How to make a Level 2 Appeal	. 116
7.	How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon	. 118
7.1	During your hospital stay, you will get a written notice from Medicare that tells about your rights	. 118
7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date	. 120
7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date	
7.4	What if you miss the deadline for making your Level 1 Appeal?	. 124
8.	How to ask us to keep covering certain medical services if you think your coverage is ending too soon	127
8.1	This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF)	
	services	
8.2	We will tell you in advance when your coverage will be ending	. 127

Cha	pter
-----	------

Page 90

2010 Evidence of Coverage for Anthem SmartValue What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section	Contents	Page
8.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time	128
8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time	128
8.5	What if you miss the deadline for making your Level 1 Appeal?	132
9.	Taking your appeal to Level 3 and beyond	135
9.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals	135
9.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals	137

MAKING COMPLAINTS

10.	How to make a complaint about quality of care, waiting times, customer service, or other concerns	138
10.1	What kinds of problems are handled by the complaint process?	138
10.2	The formal name for "making a complaint" is "filing a grievance"	140
10.3	Step-by-step: Making a complaint	141
10.4	You can also make complaints about quality of care to the Quality	
	Improvement Organization	142

BACKGROUND

1. Introduction

1.1 What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Service (phone numbers are listed on the front cover of this booklet). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This chapter explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions** and making appeals.
- For other types of problems you need to use the process for making complaints.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than

2.

"organization determination" or "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

You can get help from government organizations that are not connected with us

2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you, but in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program.**

This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. For contact information, please refer to the state specific agency listing located in the back of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week.
 TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

Chapter	2010 Evidence of Coverage for Anthem SmartValue	Page
9.	What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	93

Section

3.

4.

To deal with your problem, which process should you use?

Should you use the process for coverage decisions and appeals? Or, should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter tells what to do for your problem or concern, START HERE

Is your problem or concern about your benefits and coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)



Go on to the next section of this chapter, Section 4: "A guide to the basics of coverage decisions and making appeals"



Skip ahead to Section 10 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service or other concerns."

COVERAGE DECISIONS AND APPEALS

A guide to the basics of coverage decisions and appeals

Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including

problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Page

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service or drug is covered and pay our share of the cost.
- But in some cases we might decide the service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

How to get help when you are asking for a coverage decision 4.2 or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

• You can call us at Customer Service (phone numbers are listed on the front cover of this booklet).

Chapter **9.**

Section (con't)

- To get free help from an independent organization that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter). For contact information, please refer to the state specific agency listing located in the back of this booklet.
- You should consider getting your doctor or other provider involved if possible, especially if you want a "fast" or "expedited" decision. In most situations involving a coverage decision or appeal, your doctor or other provider must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives").
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.
- You also have the right to hire a lawyer to act for you. You may contact your
 own lawyer, or get the name of a lawyer from your local bar association or other
 referral service. There are also groups that will give you free legal services if you
 qualify. However, you are not required to hire a lawyer to ask for any kind of
 coverage decision or appeal a decision.

Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

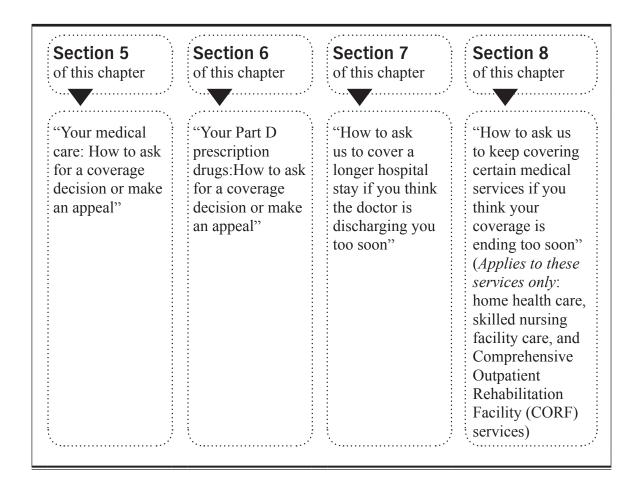
Section (con't)

5.

5.1

Chapter

9.



If you're still not sure which section you should be using, please call Customer Service (phone numbers are listed on the front cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program. For contact information, please refer to the state specific agency listing located in the back of this booklet.

Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (A guide to "the basics" of coverage decisions and appeals)?

If not, you may want to read it before you start this section.

This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These are the benefits described in the Benefit Chart located in the front of this booklet and Chapter 4. (What is covered and what you pay). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells what you can do if you are in any of the five following situations:

- 1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
- 2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
- 3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
- 4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
- 5. You are being told that coverage for certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - NOTE: If the coverage that will be stopped is for hospital care, home
 health care, skilled nursing facility care, or Comprehensive Outpatient
 Rehabilitation Facility (CORF) services, you need to read a separate section
 of this chapter because special rules apply to these types of care. Here's what
 to read in those situations:
 - Chapter 9, Section 7: How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.
 - Chapter 9, Section 8: How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon. This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
 - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do. (Section 5 does not apply to Part D drugs, see Section 6 for information on Part D drug appeals)

Which of these situations are you in?

Do you want to find out whether our plan will cover the medical care or services you want?

Has our plan already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?

Do you want to ask our plan to pay you back for medical care or services you have already received and paid for?

You need to ask our plan to make a coverage decision for you.

Go on to the next section of this chapter, **Section 5.2.**

You can make an **appeal**. (This means you are asking us to reconsider.)

Skip ahead to **Section 5.3** of this chapter.

You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms A coverage decision is often called an "initial determination" or "initial decision." When a coverage decision involves your medical care, the initial determination is called an "organization determination."

Step

5.2

You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast decision."

Legal Terms

A "fast decision" is called an "expedited decision."

Page

What to do if you have a problem or complaint (coverage decisions, appeals, complaints) 99

Section (con't)

How to request coverage for the medical care you want:

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, and look for the section called, How to contact our plan when you are asking for a coverage decision about your medical care.

Generally we use the standard deadlines for giving you our decision:

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 14 days after we receive your request.

- However, we can take up to 14 more days if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a "fast decision":

- A fast decision means we will answer within 72 hours.
 - **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- To get a fast decision, you must meet two requirements:
 - You can get a fast decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
 - You can get a fast decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

Chapter

9.

- If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.
- If you ask for a fast decision on your own, without your doctor's support, our plan will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested.
 (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step

Our plan considers your request for medical care coverage and we give you our answer.

Deadlines for a "fast" coverage decision:

- Generally, for a fast decision, we will give you our answer within 72 hours.
 - As explained above, we can take up to 14 more days under certain circumstances. If we take extra days, it is called "an extended time period."
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- If our answer is yes to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision:

- Generally, for a standard decision, we will give you our answer within 14 days
 of receiving your request.
 - We can take up to 14 more days ("an extended time period") under certain circumstances.
 - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Step

If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If our plan says no, you have the right to ask us to reconsider and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).
- 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

An appeal to the plan about a medical care coverage decision is called a plan "reconsideration."

Level 1 Appeal

Step



You contact our plan and make your appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

- To start your appeal, you (or your doctor or your representative) must contact our plan. For details on how to reach us for any purpose related to your appeal, go to Chapter 2, and look for section called, How to contact our plan when you are making an appeal about your medical care.
- Make your standard appeal in writing by submitting a signed request. You may also ask for an appeal by calling us at the phone number shown in Chapter 2, and look for a section called, How to contact our plan when you are making an appeal about your medical care.

- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- You can ask for a copy of the information in your appeal and add more information if you like.
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make an oral request):

Legal Terms

A "fast appeal" is also called an "expedited appeal."

• If you are appealing a decision our plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."

• The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this Section.)

Step 2.

Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were being fair and following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast" appeal:

- When we are using the fast deadlines, we must give you our answer within
 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more days.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

Section (con't)

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours.
- If our answer is no to part or all of what you requested, we will send you a written denial notice informing you that we have sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard" appeal:

- If we are using the standard deadlines, we must give you our answer within 30 calendar days after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more days.
 - o If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- If our answer is no to part or all of what you requested, we will send you a written denial notice informing you that we have sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3.

If our plan says no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

To make sure we were being fair when we said no to your appeal, our plan is required to send your appeal to the "Independent Review Organization."
When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

5.4 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Section (con't)

Legal Terms

The formal name for the "Independent Review Organization" is the "Independent Review Entity." It is sometimes called the "IRE."

Level 2 Appeal

Step



The Independent Review Organization reviews your appeal.

- The Independent Review Organization is an outside, independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This
 information is called your "case file." You have the right to ask us for a copy of
 your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all
 of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2:

- If you made a fast appeal at Level 1, the review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more days.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2:

- If you made a standard appeal to our plan at Level 1, the review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more days.

Step 2.

The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says yes to part or all of what you requested, we must authorize the medical care coverage within 72 hours or provide the service within 14 days after we receive the decision from the review organization.
- If this organization says no to your appeal, it means they agree with our plan that your request for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
 - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step

If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you are asking our plan to pay you for our share of a bill you have received for medical care? 5.5.

If you want to ask our plan for payment for medical care, start by reading Chapter 7 of this booklet: Asking the plan to pay its share of a bill you have received for medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you

paid for is a covered service, see the Benefit Chart located in the front of this booklet and Chapter 4 (What is covered and what you pay). We will also check to see if you followed all the rules for using your coverage for medical care. These rules are given in Chapter 3 of this booklet (Using the plan's coverage for your medical services).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying yes to your request for a coverage decision.)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying no to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

Section

6.

6.1

Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

?

Have you read Section 4 of this chapter (A guide to "the basics" of coverage decisions and appeals)? If not, you may want to read it before you start this section.

This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's List of Covered Drugs (Formulary) and they are medically necessary for you, as determined by your primary care doctor or other provider.

- This section is about your Part D drugs only. To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the List of Covered Drugs, rules and restrictions on coverage, and cost information, see Chapter 5 (Using our plan's coverage for your Part D prescription drugs) and Chapter 6 (What you pay for your Part D prescription drugs).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

A coverage decision is often called an "initial determination" or "initial decision." When the coverage decision is about your Part D drugs, the initial determination is called a "coverage determination."

Section (con't)

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan's List of Covered Drugs
 - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
 - · Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's List of Covered Drugs but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

Which of these situations are you in?

Request a Coverage Decision:

Do you want to ask us to make an exception to the rules or restrictions on our plan's coverage of a drug? Do you want to ask us to cover a drug for you? (For example, if we cover the drug but we require you to get approval from us first.) Do you want to ask us to pay you back for a drug you have already received and paid for?

Make an Appeal:

Has our plan already told you that we will <u>not</u> cover or pay for a drug in the way that you want it to be covered or paid for?

You can ask us to make an exception. (This is a type of coverage decision.)

Start with **Section 6.2** of this chapter.

You can ask us for a coverage decision.

Skip ahead to **Section 6.4** of this chapter.

You can ask us to pay you back. (This is a type of coverage decision.)

Skip ahead to **Section 6.4** of this chapter.

You can make an appeal. (This means you are asking us to reconsider.)

Skip ahead to **Section 6.5** of this chapter.

Chapter	2010 Evidence of Coverage for Anthem SmartValue	Page
9.	What to do if you have a problem or complaint (coverage decisions, appeals, complaints	s) 109

Section

6.2 | What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a Part D drug for you that is not on your plan's List of Covered Drugs (Formulary). (We call it the "Drug List".)

Legal Terms

Asking for coverage of a drug that is not on your drug list is sometimes called asking for a "formulary exception."

- If we agree to make an exception and cover a drug that is not on the Drug
 List, you will need to pay the cost-sharing amount that applies to all of
 our drugs OR drugs in the non-preferred brand tier. You cannot ask for an
 exception to the copayment or co-insurance amount we require you to pay for
 the drug.
- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

2. Removing a restriction on the plan's coverage for a covered drug.

There are extra rules or restrictions that apply to certain drugs on the plan's List of Covered Drugs (for more information, go to Chapter 5 and look for Section 5).

Legal Terms

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
 - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
 - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

 If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

Changing coverage of a drug to a lower cost-sharing tier.

Every drug on the plan's Drug List is in one of the cost-sharing tiers. The costsharing tiers used in your plan are shown in the Benefit Chart located in the front of this booklet. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal

Asking to pay a lower preferred price for a covered non-preferred **Terms** drug is sometimes called asking for a "tiering exception."

- If your drug is in the non-preferred brand tier you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred brand tier. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in the Specialty Drug tier.

Important things to know about asking for exceptions 6.3

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the benefit year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section

6.4

Step-by-step: How to ask for a coverage decision, including an exception

Step



You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do:

- Request the type of coverage decision you want. Start by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the topic called, How to contact us when you are asking for a coverage decision about your Part D prescription drugs. Or, if you are asking us to pay you back for a drug, go to the topic called, where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.
- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- If you want to ask our plan to pay you back for a drug, start by reading Chapter 7 of this booklet: Asking our plan to pay its share of a bill you have received for medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are requesting an exception, provide the "doctor's statement." Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 6.2 and 6.3 for more information about exception requests.

If your health requires it, ask us to give you a "fast decision":

Legal
Terms

A "fast decision" is called an

"expedited decision."

Section (con't)

• When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.

• To get a fast decision, you must meet two requirements:

- You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back
 for a drug you are already bought.)
- You can get a fast decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- If your doctor or other prescriber tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2.

Our plan considers your request and we give you our answer.

Deadlines for a "fast" coverage decision:

- If we are using the fast deadlines, we must give you our answer within 24 hours.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
 - o If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

Chapter

9.

- If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision:

- If we are using the standard deadlines, we must give you our answer within 72 hours.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
 - o If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- If our answer is yes to part or all of what you requested
 - If we approve your request for coverage, we must provide the coverage
 we have agreed to provide within 72 hours after we receive your request or
 doctor's statement supporting your request.
 - If we approve your request to pay you back for a drug you already bought, we are also required to **send payment to you within 30 calendar days** after we receive your request or doctor's statement supporting your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Step 3.

If we say no to your coverage request, you decide if you want to make an appeal.

• If our plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Level 1 Appeal

Section (con't)

Legal Terms

When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

An appeal to your plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step

You contact your plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

- To start your appeal, you (or your representative or your doctor or other prescriber) must contact your plan.
 - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the topic called, How to contact us when you are asking for a coverage decision, appeal, or complaint about your Part D prescription drugs.
- Make your appeal in writing by submitting a signed request.
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- You can ask for a copy of the information in your appeal and add more information.
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal":

Legal Terms

A "fast appeal" is also called an "expedited appeal."

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast decision" in Section 6.4 of this chapter.

9.

Chapter

Section Step

Our plan considers your appeal and we give you our answer.

• When we review your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast" appeal:

- If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal:

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is yes to part or all of what you requested
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than** 7 calendar days after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Section

Step

If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If your plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Step-by-step: How to make a Level 2 Appeal 6.6

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms The formal name for the "Independent Review Organization" is the "Independent Review Entity." It is sometimes called the "IRE."

Level 2 Appeal

Step

1.

To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include instructions on how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step

The Independent Review Organization does a review of your appeal and gives you an answer.

• The Independent Review Organization is an outside, independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our plan.

Section (con't)

 Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast" appeal at Level 2:

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request.
- If the Independent Review Organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.

Deadlines for "standard" appeal at Level 2:

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal.
- · If the Independent Review Organization says yes to part or all of what you requested -
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization within 72 hours after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within **30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Chapter 9.

7.1

Section Step



If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the plan's coverage for your hospital care, including any limitations on this coverage, see the Benefit Chart located in the front of this booklet and Chapter 4 (What is covered and what you pay).

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date." Our plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

During your hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

Section (con't)

1. Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- What to do if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can "make an appeal." Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 7.2 below tells how to make this appeal.)

2. You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does** *not* **mean** you are agreeing on a discharge date.
- **3. Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
 - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048). You can also see it online at www.cms.hhs.gov.

Section

7.2

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- Ask for help if you need it. If you have questions or need help at any time, please call Customer Service (phone numbers are listed on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance. For contact information, please refer to the state specific agency listing located in the back of this booklet.

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Legal Terms

When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

Step

1.

Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

Legal Terms

A "fast review" is also called an "immediate review" or an "expedited review."

What is the Quality Improvement Organization?:

This organization is a group of doctors and other health care professionals who
are paid by the federal government. These experts are not part of our plan. This
organization is paid by Medicare to check on and help improve the quality of care
for people with Medicare. This includes reviewing hospital discharge dates for
people with Medicare.

9.

Chapter

Section (con't)

How can you contact this organization?:

• The written notice you received (An Important Message from Medicare) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the state specific agency listing located in the back of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital after your
 discharge date without paying for it while you wait to get the decision on your
 appeal from the Quality Improvement Organization.
 - If you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms

A "fast review" is also called an "immediate review" or an "expedited review."

Step



The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?:

• Health professionals at the Quality Improvement Organization (we will call them "the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

This written explanation is called the "**Detailed Notice of Discharge.**" You can get a sample of this notice by calling Customer Service or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at www.cms.hhs.gov/BNI/

Step



Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?:

- If the review organization says yes to your appeal, our plan must keep providing your covered hospital services for as long as these services are medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the Benefit Chart and Chapter 4 of this booklet).

What happens if the answer is no?:

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **our plan's coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4.

If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

• If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Page

What to do if you have a problem or complaint (coverage decisions, appeals, complaints) 123

Section

7.3

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Step

Here are the steps for Level 2 of the appeal process:



You contact the Quality Improvement Organization again and ask for another review.

• You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2.

The Quality Improvement Organization does a second review of your situation.

• Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3.

Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- Our plan must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. Our plan must continue providing coverage for your hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision." It is also called "turning down your appeal."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Chapter **9.**

Section

7.4



If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms

A "fast" review (or "fast appeal") is also called an

"expedited" review (or "expedited appeal").

Step



Contact our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1.2 and look for the section called, How to contact our plan when you are making an appeal about your medical care.
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Section

Step



Our plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step



Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- If our plan says yes to your fast appeal, it means we have agreed with you that you still need to be in the hospital after the discharge date and we will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- If our plan says no to your fast appeal, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital *after* your planned discharge date, then **you may have** to pay the full cost of hospital care you received after the planned discharge date.

Step 4.

If our plan says no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

 To make sure we were being fair when we said no to your fast appeal, our plan is required to send your appeal to the "Independent Review Organization." When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 Alternate Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms The formal name for the "Independent Review Organization" is the "Independent Review Entity." It is sometimes called the "IRE."

Section Step

We will automatically forward your case to the Independent **Review Organization.**

• We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step



The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The Independent Review Organization is an outside, independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- If this organization says yes to your appeal, then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- If this organization says no to your appeal, it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal.")
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3.

If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section

8.

How to ask us to keep covering certain medical services if you think your coverage is ending too soon

This section is about three services only:

Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care only:

- · Home health care services you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, Definitions of important words.)
- Rehabilitation care you are getting as an outpatient at a Medicare-approved
 Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means
 you are getting treatment for an illness or accident, or you are recovering from a
 major operation. (For more about this type of facility, see Chapter 12, Definitions
 of important words.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see the Benefit Chart located in the front of this booklet and Chapter 4 (What is covered and what you pay).

When our plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, our plan will stop paying its share of the cost for your care.

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask.

8.2 We will tell you in advance when your coverage will be ending

- **1. You will receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a letter or notice.
 - The written notice tells you the date when our plan will stop covering the care for you.

Chapter

9.

Legal Terms

In this written notice, we are telling you about a "coverage decision" we have made about when to stop covering your care. (For more information about coverage decisions, see Section 4 in this chapter.)

 The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling what you can do, the written notice is telling how you can "make an appeal." Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (Section 8.3 below tells how you can make an appeal.)

The written notice is called the "Notice of Medicare Non-Coverage." To get a sample copy, call Customer Service or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at www.cms.hhs.gov/BNI/

2. You must sign the written notice to show that you received it.

- You or someone who is acting on your behalf must sign the notice.
 (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does** <u>not</u> mean you agree with the plan that it's time to stop getting the care.

Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

• **Follow the process.** Each step in the first two levels of the appeals process is explained below.

Section (con't)

- Meet the deadlines. The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- Ask for help if you need it. If you have questions or need help at any time,
 please call Customer Service (phone numbers are listed on the front cover of this
 booklet). Or call your State Health Insurance Assistance Program, a government
 organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Legal Terms

When you start the appeal process by making an appeal, it is called the "first level of appeal" or "Level 1 Appeal."

Step

1.

Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?:

• This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?:

• The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the state specific agency listing located in the back of this booklet.

What should you ask for?:

• Ask this organization to do an independent review of whether it is medically appropriate for our plan to end coverage for your medical services.

Your deadline for contacting this organization:

You must contact the Quality Improvement Organization to start your appeal no
later than noon of the day after you receive the written notice telling you when we
will stop covering your care.

Section (con't)

• If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

Step



The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?:

- Health professionals at the Quality Improvement Organization (we will call them
 "the reviewers") will ask you (or your representative) why you believe coverage
 for the services should continue. You don't have to prepare anything in writing, but
 you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- During this review process, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

Legal Terms

This written explanation is called the

"Detailed Explanation of Non-Coverage."

Step



Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?:

- If the reviewers say *yes* to your appeal, then **our plan must keep providing your** covered services for as long as it is medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the Benefit Chart located in the front of this booklet and Chapter 4).

What happens if the reviewers say no to your appeal?:

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Section

Chapter

9.

Step 4.

If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal <u>and</u> you choose to continue getting care after your coverage for the care has ended then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal <u>and</u> you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Step

Here are the steps for Level 2 of the appeal process:



You contact the Quality Improvement Organization again and ask for another review.

You must ask for this review within 60 days after the day when the Quality
Improvement Organization said no to your Level 1 Appeal. You can ask for this
review only if you continued getting care after the date that your coverage for the
care ended.

Step



The Quality Improvement Organization does a second review of your situation.

• Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step



Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?:

- Our plan must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. Our plan must continue providing coverage for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

9.

What happens if the review organization says no?:

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step

If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you miss the deadline for making your Level 1 Appeal? 8.5 You can appeal to our plan instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal

A "fast" review (or "fast appeal") is also called an

"expedited" review (or "expedited appeal").

Chapter 9.

> Section Step



Contact our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1.2 and look for the topic called, How to contact our plan when you are making an appeal about your medical care.
- Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step



Our plan does a "fast" review of the decision we made about when to stop coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were being fair and following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step



Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- If our plan says yes to your fast appeal, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- If our plan says no to your fast appeal, then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, then you will have to pay the full cost of this care yourself.

Step



If our plan says *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

• To make sure we were being fair when we said no to your fast appeal, we are required to send your appeal to the "Independent Review Organization." When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Section (con't)

Step-by-Step: How to make a Level 2 Alternate Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the "Independent Review Organization" is the "Independent Review Entity." It is sometimes called the "IRE."

Step



We will automatically forward your case to the Independent Review Organization.

We are required to send the information for your Level 2 Appeal to the
Independent Review Organization within 24 hours of when we tell you that we
are saying no to your first appeal. (If you think we are not meeting this deadline
or other deadlines, you can make a complaint. The complaint process is different
from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step



The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The Independent Review Organization is an outside, independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- If this organization says yes to your appeal, then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- If this organization says *no* to your appeal, it means they agree with the decision our plan made to your first appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process.
 It will give you the details about how to go on to a Level 3 Appeal.

Section Step

Chapter

9.

3. If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Taking your appeal to Level 3 and beyond

9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal

A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- If the answer is yes, the appeals process *may* or *may not* be over. We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4
 Appeal request with any accompanying documents. We may wait for the Level
 4 Appeal decision before authorizing or providing the service in dispute.

Chapter

9.

- If the answer is no, the appeals process may or may not be over.
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal

The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

- If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over.
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - o If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

• This is the last step of the administrative appeals process.

Section

9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal

A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved.
- If the answer is no, the appeals process may or may not be over.
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal

The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

- If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved.
- If the answer is no, the appeals process may or may not be over.
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare

Section (con't)

10.

Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

• This is the last step of the administrative appeals process.

MAKING COMPLAINTS

How to make a complaint about quality of care, waiting times, Customer Service, or other concerns

?

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

Chapter

9.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

• Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Service department has dealt with you?
- Do you feel you are being encouraged to leave our plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health profeseionals? Or by Customer Service or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.

Cleanliness

• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from our plan

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

(The next page has more examples of possible reasons for making a complaint)

Section (con't)

10.2

Possible complaints (continued)

These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

The formal name for "making a complaint" is "filing a grievance."

Legal Terms

- What this section calls a "complaint" is also called a "grievance."
- Another term for "making a complaint" is "filing a grievance."
- Another way to say "using the process for complaints" is "using the process for filing a grievance."

Section

10.3 Step

Step-by-step: Making a complaint

Contact us promptly - either by phone or in writing.

- Usually, calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know. See Chapter 2 for information about how to contact Customer Service.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:
 - You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the court or in accordance with state law to act for you. If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service (phone numbers are listed on the front cover of this booklet).
 - A grievance must be filed either verbally or in writing within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
 - A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.
- Whether you call or write, you should contact Customer Service right away.

 The complaint must be made within 60 days after you had the problem you want to complain about.
- If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours.

Legal Terms

What this section calls a "fast complaint" is also called a "fast grievance."

Section Step



We look into your complaint and give you our answer.

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- Most complaints are answered in 30 days, but we may take up to 44 days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.
- If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to your plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- You can make your complaint to the Quality Improvement Organization. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, refer to the state specific agency listing located in the back of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.
- Or you can make your complaint to both at the same time. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

10.

Ending your membership in your plan

Section	Contents	Page
1.	Introduction	144
1.1	This chapter focuses on ending your membership in our plan	144
2.	When can you end your membership in our plan?	144
2.1	You can end your membership during the Annual Enrollment Period for Individual (non-group) plans	145
2.2	You can end your membership during the Individual (non-group) Medicare Advantage Open Enrollment Period, but your plan choices are more limited	146
2.3	In certain situations, you can end your membership during a Special Enrollment Period	147
2.4	Where can you get more information about when you can end your membership?	148
3.	How do you end your membership in our plan?	148
3.1	You end your membership by enrolling in another plan	148
4.	Until your membership ends, you must keep getting your medical services and drugs through our plan	149
4.1	Until your membership ends, you are still a member of our plan	149
5.	We must end your membership in the plan in certain situations	150
5.1	When must we end your membership in the plan?	150
5.2	We cannot ask you to leave our plan for any reason related to your health	151
5.3	You have the right to make a complaint if we end your membership in our plan	151

Section

Chapter

10.

1. Introduction

1.1 This chapter focuses on ending your membership in your plan

Ending your membership in your plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave your plan because you have decided that you want to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

2. When can you end your membership in your plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

If you do not want to remain enrolled in your employer or union-sponsored plan, the key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election period") for Individual (non-group)plans, which occurs every year from November 15 through December 31. This is the time to review your health care coverage for the following year and make changes to your Medicare health coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get Extra Help, or who move, can make changes at other times. In addition to the rules above, Employer/ Union Groups may allow changes to their retiree's enrollment at:

2.1

Chapter

10.

- 1. The Employer/Union's open enrollment period may be any time of the year and does not have to coincide with the individual open enrollment period from 11/15-12/31.
- 2. Please check with your prior employer/union for additional enrollment / disenrollment options and the impact of any changes to your employer/union sponsored retiree benefits.

You can end your membership during the Annual Enrollment Period for Individual (non-group) plans

You can end your membership during the **Annual Enrollment Period for Individual** (non-group) plan (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- When is the Annual Enrollment Period for Individual (non-group) plan? This happens every year from November 15 to December 31.
- What type of plan can you switch to during the Annual Enrollment Period for Individual (non-group) plans? During this time, you can review your health coverage and prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - An Individual (non-group) Medicare Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare with a separate Individual (non-group) Medicare prescription drug plan
 - \circ or Original Medicare *without* a separate Individual (non-group) Medicare prescription drug plan.
 - Ending your employer or union sponsored Medicare Advantage plan
 may impact your eligibility for other coverage sponsored by your employer
 or mean that you will not be able to re-enroll in the employer plan
 in the future. Before ending your employer sponsored Medicare
 Advantage coverage, please contact your (or your spouse's) current
 or former employer.

Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard prescription drug coverage.)

2.2

- What do you need to do to switch plans?
 - If you want to switch to Original Medicare and join a Medicare prescription drug plan: Simply join the new plan. You will be disenrolled from our plan and enrolled in Original Medicare when your new drug plan's coverage begins.
 - If you are planning on switching to Original Medicare without a drug plan: Contact Customer Service for information on how to request disenrollment. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048.
- When will your employer or union sponsored plan membership end?

 Your membership will end on the first day of the month after we get your request to change plans.

You can end your membership during the individual (nongroup) Medicare Advantage Open Enrollment Period, but your plan choices are more limited

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period.**

- When is the Medicare Advantage Open Enrollment Period for Individual (non-group) plans? This happens every year from January 1 to March 31.
- What type of plan can you switch to during the Medicare Advantage Open Enrollment Period for Individual (non-group) plans? During this time, you can make *one* change to your health plan coverage. However, you may *not* add or drop prescription drug coverage during this time. Since you are currently enrolled in a Medicare Advantage plan with prescription drug coverage, this means that you can enroll in *either*:
 - An Individual (non-group) Medicare Advantage plan with prescription drug coverage.
 - \circ or Original Medicare and a separate Medicare prescription drug plan.
 - Ending your employer or union sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your employer or mean that you will not be able to re-enroll in the employer plan in the future. Before ending your employer sponsored Medicare Advantage coverage, please contact your (or your spouse's) former employer.
- When will your employer or union sponsored plan membership end? Your membership will end on the first day of the month after we get your request to change plans.

Section

Chapter

10.

2.3

In certain situations, you can end your membership during a Special Enrollment Period

Employer or union sponsored plans may allow changes to their retirees' enrollment. This typically occurs during the Employer's open enrollment period. This may be any time of the year and does not have to coincide with the individual open enrollment period from 11/15-12/31.

Please check with your (or your spouse's) union or former employer for additional enrollment and disenrollment options, and the impact of any changes to your employer sponsored retiree benefits.

In certain situations, members of this Medicare Advantage plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period.**

- Who is eligible for a Special Enrollment Period? If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
 - If you have permanently moved outside of the United States
 - If you have Medicaid.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.
 - If you live in a facility, such as a nursing home.
- When are Special Enrollment Periods? The enrollment periods vary depending on your situation.
- What can you do? If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - An Individual (non-group) Medicare Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare with a separate Individual (non-group) Medicare prescription drug plan
 - \circ or Original Medicare without a separate Medicare prescription drug plan.
 - Ending your employer sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your employer or mean that you will not be able to re-enroll in the employer plan in the future. Before ending your employer sponsored Medicare Advantage coverage, please contact your (or your spouse's) former employer.

3.

10.

• When will your employer or union sponsored plan membership end? Your membership will usually end on the first day of the month after we receive your request to change your plan.

2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- First contact your (or your spouse's) former employer's group benefit administrator to get information on options available to you.
- You can **call Customer Service** (phone numbers are listed on the front cover of this booklet).
- You can find the information in the *Medicare & You 2010* handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall.
 Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website
 (www.medicare.gov). Or, you can order a printed copy by calling
 Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How do you end your membership in your employer or union sponsored Part D plan?

3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another health plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). One exception is when you switch from our plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact Customer Service and ask to be disenrolled from our plan.

Ending your employer or union sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your employer or mean that you will not be able to re-enroll in the employer plan in the future. Before ending your employer sponsored Medicare Advantage coverage, please contact your (or your spouse's) current or former employer.

Chapter

10.

The table below explains how you should end your membership in your plan.

If you would like to switch from our plan to:	This is what you should do:
An Individual (non-group) Medicare Advantage plan.	• Enroll in the new Medicare Advantage plan. You will automatically be disenrolled from your employer or union sponsored plan when your new plan's coverage begins.
Original Medicare with a separate Medicare prescription drug plan.	Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from your employer or union sponsored plan, when your new plan's coverage begins.
Original Medicare without a separate Medicare prescription drug plan.	 Contact Customer Service and ask to be disenrolled from the plan (phone numbers are on the cover of this booklet). You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users should call 1-877-486-2048. You will be disenrolled from your employer or union sponsored plan, when your coverage in Original Medicare begins.

Until your membership ends, you must keep getting your medical services and drugs through our plan

4.

4.1

Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- You should continue to use network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- If you are hospitalized on the day that your membership ends, you will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

5. We must end your membership in certain situations

5.1 When must we end your membership in the plan?

We must end your membership in your plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move outside of the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
 - o We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care or prescription drugs.
 - o If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If your former employer notifies us that the employer is canceling the group contract for this plan.
- If the premiums for this plan are not paid in a timely manner.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

• You can call **Customer Service** for more information (phone numbers are listed on the front cover of this booklet).

Section

5.2

We <u>cannot</u> ask you to leave your plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave your plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Cha	pter
-----	------

2010 Evidence of Coverage for Anthem SmartValue

P	age
1	52

11.

Legal notices

Section	Contents	Page
1.	Notice about governing law	153
2.	Notice about nondiscrimination	153

Section

1. Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

2. Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

12.

Definitions of important words

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Benefit period – For both this plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Brand-Name Drug - A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage -

The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have paid your true out of pocket costs for covered drugs during the covered year. You can find this amount listed on the Benefit Chart located in the front of this booklet.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs the Medicare. Chapter 2 section 2 explains how to contact CMS.

(con't) Comprehensive Outpatient Rehabilitation Facility (CORF) –

A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs or services are received. It includes any combination of the following three types of payments: (1) any "deductible" amount a plan may impose before drugs or services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific drugs or services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug or service.

Cost-sharing Tier – Every drug on the list of covered drugs is in one cost-sharing tier. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A

decision from your Medicare drug plan about whether a drug prescribed for you is covered by our plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to us to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The general term we use to mean all of the prescription drugs covered by our plan.

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug

Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial care – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Customer Service – A department within this plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Deductible – The amount you must pay for the drugs you receive before our plan begins to pay its share of your covered drugs.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable medical equipment (DME) -

Certain medical equipment that is ordered by your doctor for use in the home. Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. Examples are walkers, wheelchairs, or hospital beds.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information –

This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on our plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an

exception if our plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the plan.

Generic Drug - A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance - A type of complaint you make about us, our network pharmacies or a provider, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home health aide - A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Stage – This is the stage after you have met your deductible (if you have one) and before your total drug expenses, have reached your initial

coverage limit, including amounts you have paid and what we have paid on your behalf. To find out if our plan includes an initial coverage limit, refer to the Benefit Chart located in the front of this booklet.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

List of Covered Drugs (Formulary)

- A list of covered drugs provided by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brandname and generic drugs.

Low Income Subsidy/Extra Help -

A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Medically necessary – Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan -

Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Feefor-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Managed Care Plan -

Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Prescription Drug Coverage (Medicare Part D) –

Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare supplement insurance) policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in this plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network pharmacy – A network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with us. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider - A network provider is a provider who contracts with this plan to provide services at a lower or sometimes no cost-sharing to you.

Organization Determination - The

Medicare Advantage organization has made an organization determination when it, or one a providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare – ("Traditional Medicare" or "Fee-for-service" Medicare) Original Medicare is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network pharmacy - A

pharmacy that doesn't have a contract with us to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Part C – see "Medicare Advantage (MA) Plan"

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Provider Organization

Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing may be higher when plan benefits are received from out-of-network providers.

Primary Care Physician (PCP) - A

health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. This PFFS plan does not require you to use a PCP

Prior authorization – Approval in advance for certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other plan provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary. In a PFFS plan you do not need prior authorization to obtain medical services. However, you may want to check with our plan before obtaining services to confirm that the medical service is covered by our plan and what your cost share responsibility is.

Provider - "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services.

Quality Improvement Organization

(QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. For contact information, please refer to the state specific agency listing located in the back of this booklet.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation services – These services include physical therapy, speech and language therapy, and occupational therapy.

Select Generics - A specific list of generic drugs that have been on the market long enough to have a proven track record for effectiveness and value. A complete list of these drugs is included in your drug list (Formulary) that accompanies this Evidence of Coverage. Some plans have reduced copayments for Select Generics. If your plan includes a reduced copayment, you can find this information listed on the Benefit Chart located in the front of this booklet.

Service area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income

(SSI) - A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Screening exam - A routine exam to detect evidence of unsuspected disease.

Skilled Nursing Facility (SNF) care

- A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech

therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Specialty drugs - The Centers for Medicare & Medicaid Services (CMS) defines specialty drugs as any drug that costs \$600 or more per unit.

Urgently needed care – (Chapter 3 Section 2) explains urgently needed services. These are different from emergency services.

13.

Contact information for agencies

1.	State Health Insurance Assistance (SHIP)	162
2.	Quality Improvement Organizations (QIO)	169
3.	State Medicaid Offices	176
4.	State Medicare Offices	183
5.	State Pharmacy Assistance Program (SPAP)	184
6.	Civil Rights Commission	190

ALABAMA

Alabama Department of Senior Services

770 Washington Avenue, RSA Plaza, Suite 470 Montgomery, AL 36130-1851 1-800-AGELINE; 1-334-242-5743 TTY/TDD: 711 www.adss.state.al.us/

ALASKA

Department of Health & Social Services Division of Senior & Disabilities Services

31-601 C Street, Suite 310 Anchorage, AK 99503 1-800-478-6065 TTY/TDD: 711 www.hss.state.ak.us/dsds/medicare/

ARIZONA

Arizona Department of Economic Security

1789 West Jefferson, Suite 950A Phoenix, AZ 85007 1-800-432-4040 TTY/TDD: 711 https://egov.azdes.gov/cmsinternet/

ARKANSAS

Arkansas Insurance Department

1200 West Third Street, Little Rock, AR 72201 1-800-224-6330; 1-501-371-2782 TTY/TDD: 711 http://insurance.arkansas.gov/seniors/ homepage.htm

CALIFORNIA

California Department of Aging

1300 National Drive, Suite 200 Sacramento, CA 95834-1992 1-800-434-0222 TTY/TDD: 1-800-735-2929

Health Insurance Counseling and Advocacy Program HICAP of California

1600 K Street, Sacramento, CA 95814 1-800-434-0222 TTY/TDD: 711 www.aging.ca.gov/information_on/hicap.asp

COLORADO

Department of Regulatory Agencies

1560 Broadway, Suite 1550 Denver, CO 80202 1-888-696-7213 TTY/TDD: 1-303-894-7880

www.dora.state.co.us/insurance/

CONNECTICUT

Connecticut Department of Social Services

25 Sigourney Street, 10th Floor Hartford, CT 06106 1-800-994-9422 TTY/TDD: 1-860-424-5274 www.ct.gov/agingservices/site/

DELAWARE

ELDERinfo

841 Silver Lake Boulevard, Dover, DE 19904 1-800-336-9500

TTY/TDD: 711

http://delawareinsurance.gov/departments/elder/

DISTRICT OF COLUMBIA

District of Columbia Office on Aging

441 4th Street NW, Suite 900S Washington, DC 20739-0668

1-202-739-0668

TTY/TDD: 1-202-973-1079

www.dcoa.dc.gov/

FLORIDA

Florida Department of Elder Affairs

4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000

1-800-963-5337

TTY/TDD: 1-850-414-2001

www.floridashine.org/

GEORGIA

GeorgiaCares

2 Peachtree Street NW, 36th floor Atlanta, GA 30303

1-800-669-8387; 1-404-657-5334

TTY/TDD: 711

www.dhr.georgia.gov/

HAWAII

Executive Office on Aging Department of Health

250 S. Hotel Street, Suite 406 Honolulu, HI 96813

1-888-875-9229; 1-808-586-0100

TTY/TDD: 711

http://hawaii.gov/health/eoa/

ILLINOIS

Illinois Division of Insurance

320 W. Washington 4th Floor Springfield, IL 62767

1-800-548-9034; 1-217-782-4515

TTY/TDD: 1-217-524-4872 http://insurance.illinois.gov

INDIANA

State Health Insurance Assistance Program

311 West Washington St, Suite 300 Indianapolis, IN 46204

1-800-452-4800; 1-765-608-2318

TTY/TDD: 1-800-743-3333 www.in.gov/idoi/2393.htm

State of Idaho Department of Insurance

P.O. Box 83720, 700 West State Street Boise, ID 83720-0043

1-800-247-4422; 1-208-334-4250

TTY/TDD: 711 www.doi.idaho.gov

IOWA

Senior Health Insurance Information Program

330 Maple Des Moines, IA 50319 1-800-351-4664

TTY/TDD: 1-800-735-2942

www.shiip.state.ia.us

KANSAS

Kansas Department on Aging

503 S. Kansas Topeka, KS 66603 1-800-860-5260 TTY/TDD: 711 www.kfmc.org

Senior Health Insurance Counseling for Kansas

503 S. Kansas Topeka, KS 66603 1-800-432-3535; 1-785-296-4986 TTY/TDD: 1-785-291-3167 www.agingkansas.org

KENTUCKY

State Health Insurance Assistance Program

275 East Main St Frankfort, KY 40621 1-877-293-7447; 1-502-564-6930 TTY/TDD: 1-800-627-4702 www.chfs.ky.gov

LOUISIANA

Senior Health Insurance Information Program

Louisiana Department of Insurance, P.O. Box 94214 Baton Rouge, LA 70804 1-800-259-5301; 1-225-342-5900 TTY/TDD: 711 www.ldi.state.la.us

MAINE

Maine State Health Insurance Assistance Program SHIP Office of Elder Services

11 State House Station, 32 Blossom Lane Augusta, ME 04333 1-800-262-2232; 1-207-287-9200 TTY/TDD: 1-800-606-0215 www.maine.gov/dhhs/oes

MARYLAND

Senior Health Insurance Assistance Program SHIP Maryland Department of Aging

301 W. Preston Street, Suite 1007 Baltimore, MD 21201 1-800-243-3425; 1-410-767-1100 TTY/TDD: 1-800-637-4113 www.mdoa.state.md.us

MASSACHUSETTS

Executive Office of Elder Affairs

One Ashburton Place, 5th floor (The McCormack Building) Boston, MA 02108 1-800-243-4636; 1-617-727-7750 TTY/TDD: 1-800-872-0166 (MA Only)

www.800ageinfo.com

MICHIGAN

MMAP Medicare/Medicaid Assistance Program Michigan Office of Services to the Aging

7109 W. Saginaw Highway Lansing, MI 48917

1-800-803-7174

TTY/TDD: 711

www.seniorresources.us/MMAP.html

MINNESOTA

Minnesota Board on Aging

P.O. Box 64976 St. Paul, MN 55164-0976

1-800-882-6262; 1-651-431-2500

TTY/TDD: 1-800-627-3529

www.mnaging.org

MISSISSIPPI

Mississippi Division of Aging and Adult Services

Mississippi Department of Human Services, 750 N. State St. Jackson, MS 39202

1-800-345-6347; 1-601-359-4929

TTY/TDD: 1-800-676-4154

www.mdhs.state.ms.us/aas_info.html

MISSOURI

Community Leaders Assisting the Insured of MO CLAIM

200 North Keene Street Columbia, MO 65210

1-800-390-3330; 1-800-735-2466

TTY/TDD: 711

www.missouriclaim.org

MONTANA

Montana State Health Insurance Assistance Program

111 Sander Street, P.O. Box 4210 Helena, MT 59604

1-800-551-3191; 1-406-444-7788

TTY/TDD: 711

www.dphhs.mt.gov

NEBRASKA

Nebraska Senior Health Insurance Information Program

941 O Street, Suite 400 Lincoln, NE 68508

1-800-234-7119; 1-402-471-2201

TTY/TDD: 1-800-833-7352

www.doi.ne.gov/shiip

NEVADA

State Health Insurance Advisory Program

3416 Goni Road, Suite D #132 Carson City, NV 89706

1-800-307-4444; 1-702-486-3478

TTY/TDD: 711 www.nvaging.net

NEW HAMPSHIRE

New Hampshire ServiceLink Resource Center

129 Pleasant Street State Office Park Concord, NH 03301-3857

1-866-634-9412

TTY/TDD: 711

www.nh.gov/servicelink/

NEW JERSEY

State Health Insurance Assistance Program

P.O. Box 360

Trenton, NJ 08625-0360

1-800-792-8820; 1-877-222-3737

TTY/TDD: 711

www.state.nj.us/health/senior/ship.htm

NEW MEXICO

Benefits Counseling Program

2550 Cerrillos Road Santa Fe, NM 87505

1-800-432-2080; 1-505-476-4846

TTY/TDD: 711

www.nmaging.state.nm.us

NEW YORK

Health Insurance Information Counseling and Assistance Program New York State Office for the Aging

2 Empire State Plaza Albany, NY 12223-1251

1-800-342-9871

TTY/TDD: 711

www.aging.ny.gov/Index.cfm

Medicare Rights Center

1460 Broadway 17th Floor New York, NY 10036

1-800-333-4114; 1-212-869-3850

TTY/TDD: 711

NORTH CAROLINA

Seniors' Health Insurance Information **Program**

11 South Boylan Avenue Raleigh, NC 27603

1-800-443-9354; 1-919-807-6900

TTY/TDD: 1-919-715-0319

www.ncdoi.com/Consumer/SHIIP/SHIIP.asp

NORTH DAKOTA

Senior Health Insurance Counseling SHIC North Dakota Insurance Department

600 East Boulevard, Fifth Floor Bismarck, ND 58505-0320

1-800-247-0560; 1-701-328-2440

TTY/TDD: 1-800-366-6888

www.nd.gov/ndins/

OHIO

The Ohio Senior Health Insurance Information Program OSHIIP

50 W. Town Street, 3rd Floor, Suite 300 Columbus, OH 43215

1-800-686-1578; 1-614-644-2658

TTY/TDD: 1-614-644-3745

www.insurance.ohio.gov

OKLAHOMA

Senior Health Insurance Counseling Program SHIP Oklahoma Insurance Department

2401 N.W. 23rd, Suite 28 Oklahoma City, OK 73107

1-800-763-2828; 1-405-521-6628

TTY/TDD: 711

www.ok.gov/triton

OREGON

Chapter

13.

Senior Health Insurance Benefits Assistance Program

250 Church Street SE, Suite 200 Salem, OR 97301-3921

1-800-722-4134; 1-503-378-2014

TTY/TDD: 1-800-735-2900

http://oregonshiba.org

PENNSYLVANIA

Department of Public Welfare of Pennsylvania

2601 Market Place Street, Suite 320 Harrisburg, PA 17110

1-877-346-6180; 1-717-671-5425

TTY/TDD: 711

www.dpw.state.pa.us

RHODE ISLAND

The Point

35 Howard Avenue Cranston, RI 02921

1-401-462-4444

TTY/TDD: 1-401-462-4445

http://adrc.ohhs.ri.gov

SOUTH CAROLINA

South Carolina's Lieutenant Governor's Office of Aging

1301 Gervais Street, Suite 200 Columbia, SC 29201

1-800-868-9095; 1-803-734-9900

TTY/TDD: 711

www.aging.sc.gov

SOUTH DAKOTA

Senior Health Information & Insurance Education SHINE South Dakota Department of Social Services

700 Governors Drive Pierre, SD 57501-2291

1-800-536-8197

TTY/TDD: 711

TENNESSEE

TN Commission on Aging and Disability **SHIP TN Commission on Aging** and Disability

500 Deaderick Street, Suite 825 Nashville, TN 37243-0860

1-877-801-0044; 1-615-741-2056

TTY/TDD: 1-615-532-3893

www.state.tn.us

TEXAS

Health Information Counseling and Advocacy Program Texas Department of Aging and Disability Services

P.O. Box 14200

Midland, TX 79711-4200

1-800-252-8263

TTY/TDD: 1-512-424-6597

www.hhsc.state.tx.us

UTAH

Senior Health Insurance Information Program

120 North 200 West, Room 325 Salt Lake City, UT 84103

1-800-541-7735; 1-801-538-3910

TTY/TDD: 711

www.hsdaas.utah.gov

VERMONT

Vermont State Health Insurance Assistance Program

481 Summer Street, Suite 101 St. Johnsbury, VT 05819 1-800-642-5119; 1-802-748-5182 TTY/TDD: 711 www.medicarehelpvt.net

VIRGINIA

Virginia Department for the Aging

1610 Forest Avenue, Suite 100 Richmond, VA 23229 1-800-552-3402; 1-804-662-9333 TTY/TDD: 711 www.vda.virginia.gov

Virginia Insurance Counseling and Assistance Program Commonwealth of Virginia Department for the Aging

1610 Forest Avenue, Suite 100 Richmond, VA 23229-5009 1-800-552-3402

TTY/TDD: 1-800-552-3402

WASHINGTON

Statewide Health Insurance Benefits Advisors

P.O. Box 40256 Olympia, WA 98504-0256 1-800-562-6900; 1-360-586-2018 TTY/TDD: 1-360-586-0241 www.insurance.wa.gov

WEST VIRGINIA

West Virginia State Health Insurance Assistance Program

1900 Kanawha Blvd. East Town Center Mall, 3rd Level Charleston, WV 25305 1-877-987-4463; 1-304-558-3317 TTY/TDD: 711 www.wvship.org

WISCONSIN

Wisconsin Department of Health and Family Services

P.O. Box 7850, 1 W. Wilson St., Rm. 618 Madison, WI 53707-7850 1-800-242-1060

TTY/TDD: 1-888-701-1255, press 1

Wisconsin SHIP

1 West Wilson Street Madison, WI 53703 1-800-242-1060; 1-608-266-1865 TTY/TDD: 1-608-267-7371 www.dhs.wisconsin.gov/aging/SHIP.htm

WYOMING

Wyoming State Health Insurance Information Program (WSHIIP)

P.O. Box BD Riverton, WY 82501 1-800-856-4398; 1-307-856-6880 TTY/TDD: 711 www.wyomingseniors.com/WSHIIP.htm

or

106 East 6th Avenue Cheyenne, WY 82002 1-800-856-4398 TTY/TDD: 711

ALABAMA

Alabama Quality Assurance Foundation

Two Perimeter Park Drive, Suite 200 West Birmingham, AL 35243-2337

1-205-970-1600

TTY/TDD: 711

Fax: 1-205-970-1600

www.aqaf.com

ALASKA

Mountain-Pacific Quality Health

4241 B Street, Suite 1-303 Anchorage, AK 99503

1-877-561-3202, 1-907-561-3202

TTY/TDD: 711

Fax: 1-907-561-3204

www.mpqhf.com

ARIZONA

Health Services Advisory Group

1600 East Northern Ave., Suite 100

Phoenix, AZ 85020

1-602-264-6382

TTY/TDD: 711

Fax: 1-602-241-0757

www.hsag.com

ARKANSAS

Arkansas Foundation for Medical Care

401 West Capitol

Little Rock, AR 72201

1-501-212-8600

TTY/TDD: 711

Fax: 1-501-244-2101

www.afmc.org

CALIFORNIA

Lumetra

One Sansome Street San Francisco, CA 94104

1-800-841-1602, 1-415-677-2000

TTY/TDD: 711

Fax: 1-415-677-2195 www.lumetra.com

COLORADO

Colorado Foundation for Medical Care

23 Inverness Way East, Suite 100 Englewood, CO 80112-5708

1-303-695-3300

TTY/TDD: 711

Fax: 1-303-695-3343

www.cfmc.org

CONNECTICUT

Qualidigm

100 Roscommon Drive Middletown, CT 06457

1-860-632-2008

TTY/TDD: 711

Fax: 1-860-613-3698 www.qualidigm.org

DELAWARE

Quality Insights of Delaware

Baynard Building, Suite 100 3411 Silverside Road Wilmington, DE 19810-4812

1-302-478-3600

TTY/TDD: 711

Fax: 1-302-478-3873

www.qide.org/de/

FLORIDA

Florida Medical Quality Assurance, Inc.

5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609-1822 1-813-354-9111 TTY/TDD: 711 www.fmgai.com

GEORGIA

Georgia Medical Care Foundation

1455 Lincoln Parkway, Suite 1-800 Atlanta, GA 30346 1-800-979-7217 TTY/TDD: 711 www.gmcf.org

HAWAII

Mountain-Pacific Quality Health

1360 South Beretania, Suite 1-501 Honolulu, HI 96814 1-800-524-6550, 1-808-545-2550

TTY/TDD: 711 Fax: 1-808-440-6030

www.mpqhf.org

ILLINOIS

Illinois Foundation for Quality Health Care

2625 Butterfield Road, Suite 102E Oak Brook, IL 60523-4425

1-800-386-6431, 1-630-571-5540

TTY/TDD: 711 Fax: 1-630-571-5611

www.ifqhc.org

INDIANA

Qualis Health

720 Park Boulevard, #120 Boise, ID 83712 1-800-488-1118, 1-208-343-4617 TTY/TDD: 711

Fax: 1-208-343-4705 www.qualishealth.org/qi/

Health Care Excel, Inc

2629 Waterfront Parkway East Drive Indianapolis, IN 46214 1-800-288-1499, 1-317-347-4500

TTY/TDD: 1-800-648-6057

Fax: 1-317-347-4545

www.hce.org

IOWA

Iowa Foundation for Medical Care

1779 West Lakes Parkway West Des Moines, IA 50266 1-800-383-2856, 1-515-223-2900

TTY/TDD: 711

Fax: 1-515-222-2407

www.ifmc.org

KANSAS

Kansas Foundation for Medical Care

2947 SW Wanamaker Drive Topeka, KS 66614-4193 1-800-432-0407, 1-785-273-2552 TTY/TDD: 711 www.kfmc.org

Kansas Foundation for Medical Care

2947 SW Wanamaker Drive Topeka, KS 66614-4193

1-800-432-0407, 1-785-273-2552

TTY/TDD: 711

Fax: 1-785-273-5130

www.kfmc.org

KENTUCKY

Health Care Excel Incorporated

1941 Bishop Lane, Suite 400 Louisville, KY 40218

1-800-288-1499, 1-502-454-5112

TTY/TDD: 711

Fax: 1-502-454-5113

www.hce.org

LOUISIANA

Louisiana Health Care Review

8591 United Plaza Blvd, Suite 270 Baton Rouge, LA 70809

1-800-433-4958, 1-225-926-6353

TTY/TDD: 711

Fax: 1-225-923-0957

www.lhcr.org

MARYLAND

Delmarva Foundation for Medical Care

9240 Centreville Road Easton, MD 21601

1-800-999-3362, 1-410-822-0697

TTY/TDD: 711 www.mdqio.org

MASSACHUSETTS

MassPRO

245 Winter Street Waltham, MA 02451-1231 1-800-252-5533, 1-781-890-0011

TTY/TDD: 711

Fax: 1-781-487-0083 www.masspro.org

MICHIGAN

Michigan Peer Review Organization

22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611 1-800-365-5899, 1-248-465-7300

TTY/TDD: 711

Fax: 1-248-465-7428

www.mpro.org

MINNESOTA

Stratis Health

2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525 1-877-787-2847, 1-952-854-3306

.

TTY/TDD: 1-800-627-3529

Fax: 1-952-853-8503 www.stratishealth.org

MISSISSIPPI

Information and Quality Healthcare of Mississippi

385B Highland Colony Pkwy., Suite 504 Ridgeland, MS 39157

1-800-844-0600, 1-601-957-1575

TTY/TDD: 711

Fax: 1-601-956-1713

www.igh.org

MISSOURI

Primaris

200 North Keene Street Columbia, MO 65210

1-800-735-6776, 1-573-817-8300

TTY/TDD: 1-800-735-2966

Fax: 1-573-817-8330 www.primaris.org

MONTANA

Mountain-Pacific Quality Health Foundation

3404 Cooney Drive Helena, MT 59602

1-800-497-8232, 1-406-443-4020

TTY/TDD: 711

Fax: 1-406-443-4585

www.mpqhf.org

NEBRASKA

Cimro of Nebraska

1230 O Street, Suite 120 Lincoln, NE 68508

1-800-458-4262, 1-402-476-1399

TTY/TDD: 711

Fax: 1-402-476-1335 www.cimronebraska.org

NEVADA

Health Insight

6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118

1-800-748-6773, 1-702-385-9933

TTY/TDD: 711

Fax: 1-702-385-4586 www.healthinsight.org

NEW HAMPSHIRE

Northeast Health Care Quality Foundation

15 Old Rollinsford Road, Suite 1-302 Dover, NH 03820-2830

1-800-772-0151, 1-603-749-1641

TTY/TDD: 711

Fax: 1-603-749-1195

www.nhcqf.org

NEW JERSEY

Healthcare Quality Strategies Inc.

557 Cranbury Road, Suite 21 East Brunswick, NJ 08816-4026

1-800-624-4557, 1-732-238-5570

TTY/TDD: 711 www.pronj.org

NEW MEXICO

New Mexico Medical Review Association

5801 Osuna Road NE, Suite 200 Albuquerque, NM 87109

1-800-663-6351, 1-505-998-9898

TTY/TDD: 711 www.nmmra.org

NEW YORK

Island Peer Review Organization

1979 Marcus Avenue, 1st Floor Lake Success, NY 11042-1002

1-800-331-7767

TTY/TDD: 1-516-326-6182

Fax: 1-516-328-2310

www.ipro.org

NORTH CAROLINA

Medical Review of North Carolina, Inc.

100 Regency Forest Drive, Suite 200 Cary, NC 27518-8598

1-800-682-2650, 1-919-380-9860

TTY/TDD: 1-800-735-2962

Fax: 1-919-380-7637

www.thecarolinascenter.org

NORTH DAKOTA

North Dakota Health Care Review

800 31st Ave SW, Minot, ND 58701

1-800-472-2902, 1-701-852-4231

TTY/TDD: 711

Fax: 1-701-838-6009

www.ndhcri.org

OHIO

KePRO Rock Run Center

5700 Lombardo Center Drive Rock Run Center, Suite 100 Seven Hills, OH 44131

1-216-447-9604, 1-800-750-0750

TTY/TDD: 1-800-325-0778

Fax: 1-216-447-7925 www.ohiokepro.com

OKLAHOMA

Oklahoma Foundation for Medical Quality

14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134-2600

1-800-522-3414, 1-405-840-2891

TTY/TDD: 711

Fax: 1-405-858-9097

www.ofmq.com

OREGON

Acumentra Health

2020 SW Fourth Avenue, Suite 520 Portland, OR 97201

1-800-344-4354, 1-503-279-0100

TTY/TDD: 711

Fax: 1-503-279-0190 www.acumentra.org

PENNSYLVANIA

Quality Insights of Pennsylvania

2601 Market Place Street, Suite 320 Harrisburg, PA 17110

1-877-346-6180, 1-717-671-5425

TTY/TDD: 711 www.qipa.org

RHODE ISLAND

Quality Partners of Rhode Island

235 Promenade Street, Suite 500, Box 18 Providence, RI 02908

1-800-662-5028, 1-401-528-3200

TTY/TDD: 711

Fax: 1-401-528-3210 www.riqualitypartners.org

SOUTH CAROLINA

The Carolinas Center for Medical Excellence

246 Stoneridge Drive, Suite 200 Columbia, SC 29210

1-800-922-3089, 1-803-251-2215

TTY/TDD: 1-800-735-8583

Fax: 1-803-255-0897

www.thecarolinascenter.org

SOUTH DAKOTA

South Dakota Foundation for Medical Care

2600 West 49th Street, Suite 300, P.O. Box 7406 Sioux Falls, SD 57117-7406 1-605-336-3505

TTY/TDD: 711

TENNESSEE

Qsource

3175 Lenox Park Blvd., Suite 309 Memphis, TN 38115

1-800-528-2655, 1-901-682-0381 TTY/TDD: 711

www.qsource.org

TEXAS

TMF Health Quality Institute

Suite 300 5918 West Courtyard Drive, Bridgepoint I Austin, TX 78730-5036 1-800-725-9216, 1-512-329-6610

TTY/TDD: 711

Fax: 1-512-327-7159

www.tmf.org

UTAH

HealthInsight

348 East 4500 South, Suite 300 Salt Lake City, UT 84107

1-801-892-0155

TTY/TDD: 711

Fax: 1-801-892-0160 www.healthinsight.org

VIRGINIA

Virginia Health Quality Center (Richmond)

9830 Mayland Drive, Suite J Richmond, VA 23233

1-866-263-8402, 1-804-289-5320

TTY/TDD: 1-877-486-2048

Fax: 1-804-289-5324

www.vhqc.org

Virginia Health Quality Center (Glen Allen)

4510 Cox Road, Suite 400 Glen Allen, VA 23060

1-804-289-5320

TTY/TDD: 711

www.vhqc.org

WASHINGTON

Mountain-Pacific Quality Health

10700 Meridian N., Suite 100 Seattle, WA 98133

1-800-949-7536, 1-206-364-9700

TTY/TDD: 711

www.qualishealth.org

WEST VIRGINIA

West Virginia Medical Institute, Inc. Quality Insights

3001 Chesterfield Place Charleston, WV 25304

1-800-642-8686, 1-304-346-9864

TTY/TDD: 711 www.wvmi.org

WISCONSIN

MetaStar Inc.

2909 Landmark Place Madison, WI 53713 1-800-362-2320, 1-608-274-1940

Fax: 1-608-274-5008 www.metastar.com

TTY/TDD: 711

WYOMING

Mountain-Pacific Quality Health

2206 Dell Range Blvd., Suite G Cheyenne, WY 82009 1-877-810-6248, 1-307-637-8162

TTY/TDD: 711

Fax: 1-307-637-8163 www.mpqhf.com

or

P.O. Box 2242, 409 South 4th Glenrock, WY 82637

3. State Medicaid Offices

ALABAMA

Medicaid Agency of Alabama

501 Dexter Avenue, P.O. Box 5624 Montgomery, AL 36103 1-800-362-1504, 1-334-206-5175

TTY/TDD: 711

www.medicaid.state.al.us

ALASKA

Alaska Department of Health & Social Services

350 Main Street Room 229, P.O. Box 110601 Juneau, AK 99811-0601

1-800-780-9972, 1-800-770-5650

TTY/TDD: 711

http://health.hss.state.ak.us

ARIZONA

Arizona Department of Health Services

801 E. Jefferson Phoenix, AZ 85034

1-800-654-8713, 1-602-417-4000

TTY/TDD: 1-602-417-4191

http://www.azdhs.gov

ARKANSAS

Department of Human Services of Arkansas

P.O. Box 1437, Donaghey Plaza, Slot 1100 Little Rock, AR 72203

1-800-482-5431

TTY/TDD: 1-501-682-6789 www.arkansas.gov/dhs/

CALIFORNIA

California Department of Health Services Medi-Cal Policy Division

P.O. Box 997413 Sacramento, CA 95899-7413

1-916-636-1980

TTY/TDD: 711

www.dhs.ca.gov

California Department of Health Services

1500 Capitol Avenue, Suite 714063 Sacramento, CA 95899

1-916-552-9200

TTY/TDD: 711

COLORADO

Colorado Department of Healthcare Policy and Financing

1570 Grant Street Denver, CO 80203

1-303-866-2993, 1-303-866-3883

TTY/TDD: 1-303-866-3883

www.colorado.gov

CONNECTICUT

Department of Social Services of Connecticut

25 Sigourney Street Hartford, CT 06106

1-800-842-1508, 1-860-509-8000

TTY/TDD: 711

www.ct.gov/dss/

DELAWARE

Delaware Health and Social Services

1901 N. DuPont Highway, P.O. Box 906, Lewis Bldg. New Castle, DE 19720 1-800-372-2022, 1-302-255-9040 TTY/TDD: 711 www.dhss.delaware.gov

DISTRICT OF COLUMBIA

DC Healthy Family

825 North Capitol Street NE, 5th Floor Washington, DC 20002 1-888-557-1116 TTY/TDD: 1-202-639-4041

http://app.doh.dc.gov/

FLORIDA

Florida Department of Health

4052 Bald Cypress Way, Bin #B06 Tallahassee, FL 32399-1734 1-850-245-4494 TTY/TDD: 711 www.doh.state.fl.us

GEORGIA

Georgia Department of Community Health

2 Peachtree Street NW Atlanta, GA 30303 1-866-322-4260 TTY/TDD: 711 http://dch.georgia.gov

HAWAII

Department of Human Services of Hawaii

P.O. Box 339 Honolulu, HI 96809 1-808-587-3521

TTY/TDD: 1-808-692-7182 www.hawaii.gov/dhs/

IDAHO

Idaho Department of Health and Welfare – Division of Medicaid

3232 Elder Boise, ID 83705 1-877-200-5441 TTY/TDD: 711 www.healthandwelfare.idaho.gov

ILLINOIS

Illinois Department of Healthcare and Family Services

201 South Grand Avenue East Springfield, IL 62763 1-217-782-1200, 1-800-782-71-860, 1-800-545-2200 (Spanish) TTY/TDD: 711 www.hfs.illinois.gov

INDIANA

Family and Social Services Administration of Indiana

402 W. Washington St., P.O. Box 7083 Indianapolis, IN 46207 1-888-673-0002, 1-317-233-4454 TTY/TDD: 1-800-743-3333 www.in.gov/fssa/

IOWA

Iowa Department of Human Services

Hoover State Office Building 1305 E. Walnut Street Des Moines, IA 50319 1-800-338-8366, 1-515-281-4115 TTY/TDD: 711 www.dhs.state.ia.us

KANSAS

Department of Social and Rehabilitation Services of Kansas

915 SW Harrison, DSOB 9th Floor Topeka, KS 66612 1-800-766-9012, 1-785-274-4200 TTY/TDD: 1-785-296-1491 www.srskansas.org

Kansas Department on Aging New England Building

503 S. Kansas Ave. Topeka, KS 66603-3404 1-800-432-3535 TTY/TDD: 1-785-291-3167 www.agingkansas.org

KENTUCKY

Cabinet for Health Services of Kentucky

275 East Main Frankfort, KY 40621 1-800-635-2570, 1-502-564-4321 TTY/TDD: 1-800-627-4702 www.chfs.ky.gov

LOUISIANA

Louisiana Department of Health and Hospital

P.O. Box 629, 628 N. 4th Street Baton Rouge, LA 70821-9278 1-888-342-6207, 1-225-342-9500 TTY/TDD: 1-225-216-7387 www.dhh.louisiana.gov

MAINE

Maine Department of Health and Human Services

11 State House Station Augusta, ME 04333 1-800-977-6740, 1-207-287-9202 TTY/TDD: 1-800-606-0215 www.maine.gov/dhhs/

MARYLAND

Maryland Department of Health and Mental Hygiene

201 West Preston Street, P.O. Box 17259 Baltimore, MD 21203-7259 1-800-492-5231, 1-410-767-5800 TTY/TDD: 711 www.dhmh.state.md.us

MASSACHUSETTS

Massachusetts Office of Medicaid

One Ashburton Place, 11th Floor Boston, MA 02108 1-800-325-5231, 1-617-573-1770 TTY/TDD: 1-800-530-7570 www.mass.gov

MICHIGAN

Michigan Department of Community Health

320 South Walnut Street, Sixth Floor Lewis Cass Building Lansing, MI 48913 1-800-642-3195, 1-517-373-3740

TTY/TDD: 1-517-373-3573

www.michigan.gov/mdch

MINNESOTA

Minnesota Department of Human Services

DHHS Metro, 85 East Seventh Place, Ste. 105 St. Paul, MN 55101

1-800-657-3739, 1-651-431-2000

TTY/TDD: 1-800-627-3529

www.dhs.state.mn.us

MISSISSIPPI

Mississippi Division of Medicaid

550 High Street Suite 1000, Sillers Building Jackson, MS 39201-1399

1-800-421-2408, 1-601-359-6050

TTY/TDD: 711

www.medicaid.ms.gov

MISSOURI

Missouri Medicaid Department of Social Services Division of Medical Services

P.O. Box 6500, 615 Howerton Ct Jefferson City, MO 65102

1-800-392-2161, 1-800-735-2466

TTY/TDD: 1-800-735-2966

MONTANA

Montana Department of Public Health and Human Services Division of Child and Adult Health Resources

111 North Sanders, NW P.O. Box 4210 Helena, MT 59620

1-800-362-8312, 1-406-444-4540

TTY/TDD: 1-406-444-2590

www.dphhs.mt.gov

NEBRASKA

Nebraska Department of Health and Human Services System

P.O. Box 95044 Lincoln, NE 68509-5044

1-800-430-3244, 1-402-471-3121

TTY/TDD: 1-402-471-9570

www.hhs.state.ne.us

NEVADA

Nevada Department of Human Resources, Aging Division

3416 Goni Road, Suite D #132 Carson City, NV 89701

1-800-992-0900, 1-775-684-0800

TTY/TDD: 711

www.nvaging.net

NEW HAMPSHIRE

New Hampshire Department of Health and Human Services

129 Pleasant Street Concord, NH 03301-3857

1-800-852-3345 x5254, 1-603-271-5254

TTY/TDD: 1-800-735-2964

www.dhhs.state.nh.us

NEW JERSEY

Chapter

13.

Department of Human Services of New Jersey

P.O. Box 712, Quakerbridge Plaza Trenton, NJ 08625-0712 1-800-356-1561, 1-609-588-2600 **TTY/TDD: 711** www.nj.gov

NEW MEXICO

Department of Human Services of New Mexico

P.O. Box 2348 Santa Fe, NM 87504-2348 1-888-997-2583, 1-505-827-3184 **TTY/TDD: 711** www.hsd.state.nm.us

NEW YORK

Office of Medicaid Management, **Corning Tower**

Empire State Plaza Albany, NY 12223 1-800-541-2831, 1-518-486-9057 TTY/TDD: 711 www.health.state.ny.us/health care/medicaid

NORTH CAROLINA

North Carolina Department of Health and Human Services

2012 Mail Service Center Raleigh, NC 27699-2012 1-800-662-7030, 1-919-733-4534 TTY/TDD: 1-877-733-4851 www.dhhs.state.nc.us/dma/medicaid/

NORTH DAKOTA

Department of Human Services of North Dakota- Medical Services

600 E. Boulevard Avenue, Dept 325 Bismarck, ND 58505-0250 1-800-472-2622, 1-701-328-2310 TTY/TDD: 1-701-328-3480 www.nd.gov/dhs/

OHIO

Department of Job and Family Services of Ohio Health Plans

50 W Town Street Columbus, OH 43215 1-800-324-8680, 1-614-644-0140 TTY/TDD: 1-800-292-3572 http://jfs.ohio.gov/ohp/

OKLAHOMA

Oklahoma State Department of Health

1000 N.E. 10th Street Oklahoma City, OK 73117 1-800-522-0310, 1-405-522-5818 TTY/TDD: 1-405-271-6067 www.okhca.org

OREGON

Division of Medical Assistance Programs

Administrative Office, 500 Summer Street NE Salem, OR 97301-1079 1-800-527-5772, 1-503-945-5772 TTY/TDD: 1-800-375-2863 www.oregon.gov/DHS/healthplan/

PENNSYLVANIA

Department of Public Welfare of Pennsylvania

P.O. Box 2675, Health and Welfare Bldg. Room 515 Harrisburg, PA 17105

1-800-692-7462, 1-877-724-3258

TTY/TDD: 1-717-705-7103

www.dpw.state.pa.us

RHODE ISLAND

Rhode Island Department of Human Services

600 New London Avenue, Forand Building Div. of Health Care Quality, Fin. and Purchasing Cranston, RI 02920

1-800-984-8989, 1-401-462-5300

TTY/TDD: 1-401-462-3363

www.dhs.ri.gov

SOUTH CAROLINA

South Carolina Department of Health and Human Services

P.O. Box 8206 Columbia, SC 29202 1-888-549-0820, 1-803-898-2500 TTY/TDD: 711

www.scdhhs.gov

SOUTH DAKOTA

Department of Social Services of South Dakota

700 Governors Drive, Richard F. Kneip Bldg Pierre, SD 57501

1-800-452-7691, 1-605-773-3495

TTY/TDD: 711

TENNESSEE

Bureau of Tennessee Care

310 Great Circle Rd. Nashville, TN 37243

1-866-311-4287, 1-615-741-3111

TTY/TDD: 711

www.tn.gov/tenncare/

TEXAS

Health and Human Services Commission of Texas

4900 N. Lamar Boulevard, 4th Floor Austin, TX 78701

1-800-252-6758, 1-512-458-7111

TTY/TDD: 711

www.hhsc.state.tx.us

UTAH

Utah Department of Health Division of Health Care Financing

P.O. Box 143106 Salt Lake City, UT 84114

1-800-662-9651, 1-801-538-6155

TTY/TDD: 711

www.health.utah.gov/medicaid

VERMONT

Agency of Human Services of Vermont

103 South Main Street, Osgood 3 Waterbury, VT 05676

1-800-250-8427, 1-802-241-1282

TTY/TDD: 711

www.dcf.vermont.gov

VIRGINIA

Department Of Medical Assistance Services

600 East Broad Street Suite 1300 Richmond, VA 23219

1-804-786-7933, 1-804-786-7933 TTY/TDD: 1-800-343-0634

www.dmas.virginia.gov

WASHINGTON

Department of Social and Health Services of Washington

DSHS, PO Box 45130 Olympia, WA 98504-5130

1-800-737-0617

TTY/TDD: 711

www.dshs.wa.gov

WEST VIRGINIA

West Virginia Department of Health and Human Resources

350 Capital Street, Room 251 Office of Administration Charleston, WV 25301-3709

1-304-558-1700, 1-304-558-1703

TTY/TDD: 711

http://www.wvdhhr.org/bms/

WISCONSIN

Wisconsin Department of Health and Family Services

1 West Wilson Street Madison, WI 53703

1-800-362-3002, 1-608-266-1865

TTY/TDD: 1-608-267-7371

http://dhs.wisconsin.gov/medicaid/

WYOMING

Wyoming Department of Health

147 Hathaway Building Cheyenne, WY 82002 1-307-777-7531, 1-307-777-7656

TTY/TDD: 1-307-777-5648

Wyoming Department of Health, Equality Care (Medicaid)

401 Hathaway Building Chevenne, WY 82002

1-866-571-0944, 1-307-777-7656

TTY/TDD: 1-307-777-5648

http://wdh.state.wy.us/healthcarefin/

equalitycare

4. State Medicare Offices

Medicare

1-800-MEDICARE (1-800-633-4227)

TTY/TDD: 1-877-486-2048

Seven days a week, 24 hours a day

www.medicare.gov

CALIFORNIA

Office of the Regional Administrator 90 - 7th Street, Suite 5-300 San Francisco, CA 94103-6706

COLORADO

Office of the Regional Administrator 1600 Broadway, Suite 700 Denver, CO 80202-4367

GEORGIA

Atlanta Federal Center 61 Forsyth Street, SW, Suite 4T20 Atlanta, GA 30303-8909

ILLINOIS

Office of the Regional Administrator 233 North Michigan Avenue, Suite 600 Chicago, IL 60601

MASSACHUSETTS

Office of the Regional Administrator JFK Federal Building, Suite 2325 Boston, MA 02203-0003

MISSOURI

Office of the Regional Administrator 601 E. 12th Street, Suite 235 Kansas City, MO 64106

NEW YORK

Jacob K. Javits Federal Building 26 Federal Plaza, Room 3811 New York, NY 10278-0063

PENNSYLVANIA

Suite 216, The Public Ledger Building 150 S. Independence Mall West Philadelphia, PA 19106

TEXAS

Office of the Regional Administrator 1301 Young Street, Suite 714 Dallas, TX 75202

WASHINGTON

Office of the Regional Administrator 2201 6th Avenue, Suite 801 Seattle, WA 98121

ALABAMA

SenioRx/Wellness

770 Washington Avenue RSA Plaza Suite 470 Montgomery, AL 36130 1-800-243-5463 TTY/TDD: 711

www.adss.state.al.us/seniorx.cfm

ALASKA

Department of Health

240 Main Street, Suite 601 Juneau, AK 99811-0680 1-907-465-3372, 1-866-465-3165 TTY/TDD: 1-907-465-5430

ARIZONA

CoppeRx Card® Prescription Discount Program

1-888-227-8315, 1-800-770-8014 TTY/TDD: 711 www.rxamerica.com/az discount info.html

ARKANSAS

Department of Human Services of Arkansas / Non profit prescription assistance prog.

P.O. Box 56248 Little Rock, AR 72215 1-800-950-8233, 1-501-221-3033 TTY/TDD: 711

CALIFORNIA

California Prescription Drug Discount Program for Medicare Recipients Medi-Cal

P.O. Box 997417, MS 4604, Sacramento, CA 95814 1-916-488-5298, 1-800-434-0222 TTY/TDD: 711 www.dhcs.ca.gov

COLORADO

Colorado Bridging the Gap

4300 Cherry Creek Drive South Denver, CO 80246 1-303-692-2783, 1-303-692-2783 TTY/TDD: 711 www.cdphe.state.co.us/dc/HIVandSTD/ryanwhite/medicared.html

CONNECTICUT

Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE)

P.O. Box 5011 Hartford, CT 06102 1-800-423-5026 TTY/TDD: 711 www.connpace.com

DELAWARE

Delaware Prescription Assistance Program

P.O. Box 950 New Castle, DE 19720 1-800-996-9969 TTY/TDD: 711

www.state.de.us/dhss/dss/dpap.html

DISTRICT OF COLUMBIA

DC Healthcare Alliance

1025 15th Street, N.W. Washington, DC 20005 1-202-842-2810, 1-866-842-2810 TTY/TDD: 711

FLORIDA

Florida Comprehensive Health Association

820 E. Park Avenue Tallahassee, FL 32301 1-850-309-1200 TTY/TDD: 711

www.ncsl.org/IssuesResearch/Health/

GEORGIA

Georgia Partnership for Caring Foundation

P.O. Box 450987 Atlanta, GA 31145-0987 1-800-982-4723, 1-678-578-2920 TTY/TDD: 711

HAWAII

State Pharmacy Assistance Program

P.O. Box 700220 Kapolei, HI 96709 TTY/TDD: 711

www.gacares.org

IDAHO

RxIdaho

1-888-477-2669 TTY/TDD: 711 www.rxidaho.org

ILLINOIS

Illinois Cares Rx Illinois Department on Aging

P.O. Box 19021 Springfield, IL 62794 1-800-226-0768 TTY/TDD: 711 www.illinoiscaresrx.com

INDIANA

HoosiersRX

P.O. Box 6224 Indianapolis, IN 46206 1-317-234-1381, 1-866-267-4679 TTY/TDD: 711 www.in.gov/fssa/elderly/hoosierrx/

IOWA

Iowa prescription Drug donation program

321 E. 12th Street Des Moines, IA 50319-0075 1-866-282-5817, 1-515-327-5405 TTY/TDD: 711

KANSAS

CommunityRx Kansas

Curtis State Office Building, 1000 SW Jackson Street, Suite 540 Topeka, KS 66612 1-785-296-1086, 1-866-424-6423 TTY/TDD: 711 www.healthykansas.org

KENTUCKY

Cabinet for Health and Family Services

275 E. Main St. Frankfort, KY 40621 1-800-372-2973, 1-502-564-5497 TTY/TDD: 1-800-627-4702 www.chfs.ky.gov

MAINE

Maine Low Cost Drugs for the Elderly or Disabled Program Office of Maine Care Services

11 State House Station Augusta, ME 04333 1-866-796-2463 TTY/TDD: 711 www.mainecarepdl.org

MARYLAND

Maryland Senior Prescription Drug Assistance Program

P.O. Box 386 Baltimore, MD 21203 1-800-226-2142 TTY/TDD: 1-800-877-5156

www.marylandspdap.com

MASSACHUSETTS

Massachusetts Prescription Advantage

P.O. Box 15153 Worcester, MA 01615 1-800-243-4636

TTY/TDD: 1-877-610-0241

www.mass.gov

MICHIGAN

MiRx

Capitol View Building, 201 Townsend Street Lansing, MI 48913

1-866-755-6479, 1-800-375-1406

TTY/TDD: 711

http://www.mihealth.org/mirx/

MISSOURI

Missouri Rx Plan

P.O. Box 6500205, Jefferson Street, 14th Floor Jefferson City, MO 65101

1-800-375-1406

TTY/TDD: 711

www.morx.mo.gov

MONTANA

Big Sky Rx Program

P.O. Box 202915 Helena, MT 59620 1-866-369-1233 TTY/TDD: 711 www.bigskyrx.mt.gov

NEBRASKA

State Unit on Aging

P.O. Box 95044, 301 Contennial Mall South Lincoln, NE 68509-5044

1-800-430-3244, 1-402-471-3121

TTY/TDD: 1-402-471-9570

www.hhs.state.ne.us

NEVADA

Nevada Senior Rx Program

4126 Technology Way, Suite 101 Carson City, NV 89706 1-866-303-6323, 1-775-687-7555

TTY/TDD: 711

http://dhhs.nv.gov/Sitemap.htm

NEW HAMPSHIRE

NH Medication Bridge Program

125 Airport Road Concord, NH 03301

1-800-852-3456, 1-603-225-0900

TTY/TDD: 711

www.healthynh.com

NEW JERSEY

New Jersey Senior Gold Prescription Discount Program

P.O. Box 724

Trenton, NJ 08625

1-800-792-9745

TTY/TDD: 711

www.state.nj.us/health/seniorbenefits/

NEW MEXICO

New Mexico Medbank Program

New Mexico Aging & Long-Term Services Department, 2550 Cerrillos Road Santa Fe, NM 87505

1-800-432-2080, 1-505 476-4772

TTY/TDD: 711

www.nmaging.state.nm.us/medbank.html

NEW YORK

Elderly Pharmaceutical Insurance Coverage EPIC

P.O. Box 15018 Albany, NY 12212

1-800-332-3742

TTY/TDD: 1-800-290-9138

www.health.state.ny.us/health care/epic/

NORTH CAROLINA

Senior Health Insurance Information Program

11 S. Boyan Avenue Raleigh, NC 27603

1-800-443-9354, 1-919-807-6900

TTY/TDD: 1-919-715-0319

www.ncdoi.com/Consumer/SHIIP/SHIIP.asp

OHIO

Ohio's Best Rx

P.O. Box 408 Twinsburg, OH 44087-0408 1-866-9BESTRX, 1-614-466-9783

TTY/TDD: 1-866-763-9630

www.ohiobestrx.org

OKLAHOMA

Rx for Oklahoma

900 North Stiles Avenue Oklahoma City, OK 73104-3234 1-800-879-6552, 1-405-815-6552

TTY/TDD: 711

www.okcommerce.gov/contacts

OREGON

Oregon Prescription Drug Program

General Services Building 1225 Ferry Street SE Salem, OR 97301

1-888-411-6737, 1-503-373-1603

TTY/TDD: 711

www.oregon.gov/OHPPR/

PENNSYLVANIA

Pharmaceutical Assistance Contract for the Elderly PACE Program

1st. Health Services, 4000 Crums Mill Road Suite 301

Harrisburg, PA 17112

1-800-225-7223

TTY/TDD: 711

http://pacecares.fhsc.com

RHODE ISLAND

Rhode Island Prescription Assistance for the Elderly (RIPAE)

Attention RIPAE, John O. Pastore Center, Hazard Building, 74 West Road Cranston, RI 02920

1-401-462-3000

TTY/TDD: 711

www.dea.state.ri.us/programs/

SOUTH CAROLINA

South Carolina Gap Assistance Pharmacy Program for Seniors (GAPS)

P.O. Box 8206 Columbia, SC 29202

1-888-549-0820

TTY/TDD: 711

www.dhhs.state.sc.us

TENNESSEE

Cover Tennessee

312 Rosa L. Parks Avenue, Suite 2600 Nashville, TN 37243

1-866-268-3786

TTY/TDD: 711

www.covertn.gov

TEXAS

Texas State Pharmacy Assistance Programs

1100 W. 49th St.

Austin, TX 78756

1-800-222-3986, 1-512-458-7150

TTY/TDD: 1-512-458-7162

www.dshs.state.tx.us

UTAH

Utah Medicaid Pharmacy Program

P.O. Box 143102 Salt Lake City, UT 84114 1-801-538-6155, 1-800-662-9651 TTY/TDD: 711

VERMONT

Vermont V Pharm

312 Hurricane Lane, Suite 201 Willston, VT 05495

1-800-250-8427

TTY/TDD: 711

www.greenmountaincare.org

VIRGINIA

Department Of Medical Assistance Services

1610 Forest Avenue, Suite 100 Richmond, VA 23229 1-800-552-3402, 1-804-662-9333

TTY/TDD: 711

www.vda.virginia.gov

Virginia Department of Health SPAP Patient services Incorporated

P.O. Box 2448 Richmond, VA 23218-2448 1-800-366-7741 TTY/TDD: 711

WASHINGTON

Washington State Health Insurance Pharmacy Assistance Program

P.O. Box 1090 Great Bend, KS 67530 1-800-877-5187 TTY/TDD: 711 www.wship.org

WEST VIRGINIA

West Virginia Rx Program

1520 Washington Street, East Charleston, WV 25311 1-877-388-9879 TTY/TDD: 711

WISCONSIN

www.wvrx.org

Wisconsin Senior Care

P.O. Box 6710 Madison, WI 53716 1-800-657-2038 TTY/TDD: 711 www.dhfs.state.wi.us/seniorcare/

WYOMING

The Wyoming Prescription Drug Assistance Program (PDAP)

6101 Yellowstone, Suite 259B Cheyenne, WY 82002 1-800-438-5785, 1-307-777-6923

TTY/TDD: 711

http://wdh.state.wy.us/healthcarefin/pharmacy/

Civil Rights Commission Contact Information

(if you don't see your state, see District of Columbia)

ALABAMA

Chapter

13.

6.

Civil Rights Civil Rights/EEO

50 Ripley Street Montgomery, AL 36130 1-800-548-2547, 1-334-242-1550

TTY/TDD: 1-334-242-0196

www.usccr.gov/pubs/crd/stateloc/al.htm

ALASKA

Alaska State Commission for Human Rights

800 A Street, Suite 204 Anchorage, AK 99105-3669

1-800-478-4692, 1-907-274-4692

TTY/TDD: 1-800-478-3177

www.gov.state.ak.us/aschr/aschr.htm

ARIZONA

ARIZONA CIVIL RIGHTS DIVISION Office of the Arizona Attorney General

1275 W. Washington Street Phoenix, AZ 85007-2926

1-602-542-5263

TTY/TDD: 1-602-542-5002

www.attorney general.state.az.us

CALIFORNIA

Office for Civil Rights San Francisco Office

U.S. Department of Education Old Federal Building, 50 United Nations Plaza, Room 239 San Francisco, CA 94102-4912

1-415-556-4275 TTY/TDD: 711

Public Inquiry Unit

P.O. Box 944255 Sacramento, CA 94244-2550 1-916-322-3360 TTY/TDD: 711

COLORADO

Colorado Civil Rights Division

1560 Broadway, Suite 1050 Denver, CO 80202

1-303-894-2997, 1-800-262-4845

TTY/TDD: 711

www.dora.state.co.us/civil-rights

CONNECTICUT

Commission on Human Rights and Opportunities

21 Grand St. Hartford, CT 06106

1-860-541-3400, 1-800-477-5737

TTY/TDD: 711

www.state.ct.us/chro

DELAWARE

Delaware Human Relations Division

820 French St., 4th Floor Wilmington, DE 19801

1-302-577-5050

TTY/TDD: 711

www.state.de.us/sos/human.htm

Chapter

13.

6.

Civil Rights Commission Contact Information

(if you don't see your state, see District of Columbia) (con't)

DISTRICT OF COLUMBIA

No state CRC agency listed? Contact Washington DC Office.

U.S. Commission on Civil Rights 624 Ninth Street NW Washington, DC 20425 1-202-376-8128

TTY/TDD: 711

District of Columbia Office of Human Rights

441 4th St. NW Suite 970N Washington, DC 20001

1-202-727-3900, 1-202-724-3786

TTY/TDD: 711 ohr.dc.gov/

Office for Civil Rights: U.S. Department of Health and Human Services

200 Independence Avenue, S.W. Room 509F, HHH Building Washington, DC 20201

1-800-368-1019, 1-303-844-2024

TTY/TDD: 1-303-844-3439 www.hhs.gov/ocr/office/

FLORIDA

Florida Commission on Human Relations

Building F Suite 240, 325 John Knox Rd. Tallahassee, FL 32399-4149

1-850-488-7082, 1-800-342-8170

TTY/TDD: 711 fchr.state.fl.us/

GEORGIA

Georgia Commission on Equal Opportunity

Suite 1002 - West Tower 2 Martin Luther King Jr. Drive SE Atlanta, GA 30334

1-617-565-1340, 1-800-473-OPEN (in Georgia), Fax: 404-656-4399

TTY/TDD: 1-617-565-1343

Office for Civil Rights, U.S. Department of Health and Human Services

Atlanta Federal Center, Suite 3B70 61 Forsyth Street, S.W. Atlanta, GA 30303-8909

1-800-368-1019, 1-404-562-7886

TTY/TDD: 1-404-331-2867 www.hhs.gov/ocr/office/

HAWAII

Hawaii Civil Rights Commission

830 Punchbowl St. Room 411 Honolulu, HI 96813

1-808-586-8636

TTY/TDD: 711

www.state.hi.us/hcrc

ILLINOIS

Illinois Dept. of Human Rights

100 W Randolph St., Suite 10-100 Chicago, IL 60601

1-312-814-6200, 1-800-662-3942

TTY/TDD: 711

www.state.il.us/dhr

6.

Civil Rights Commission Contact Information

(if you don't see your state, see District of Columbia) (con't)

Office for Civil Rights, U.S. Department of Health and Human Services

233 N. Michigan Ave, Suite 240 Chicago, IL 60601 1-800-368-1019, 1-312-886-2359 TTY/TDD: 1-312-353-5693 www.hhs.gov/ocr/office/

IDAHO

Idaho Human Rights Commission

1109 Main St. 4th Floor, P.O. Box 83720 Boise, ID 83720 1-208-334-2873 TTY/TDD: 711 www.state.id.us/ihrc

KANSAS

Kansas Human Rights Commission

900 SW Jackson St., Suite 851-S Topeka, KS 66612-1258 1-785-296-3206 TTY/TDD: 711 www.ink.org/public/khrc

LOUISIANA

Louisiana Commission on Human Rights

1001 N. 23rd St., Suite 262 Baton Rouge, LA 70802 1-225-342-6969, 1-225-342-2063 TTY/TDD: 1-888-248-0859 www.gov.state.la.us/depts/lchr.htm

MAINE

Maine Human Rights Commission

51 State House Station Augusta, ME 04333-0051 1-207-624-6050 TTY/TDD: 1-888-577-6690 www.state.me.us/mhrc/

MARYLAND

Maryland Human Rights Commission

6 St. Paul St. 9th Floor Baltimore, MD 21202-1631 1-800-637-6247, 1-410-767-8600 TTY/TDD: 711 www.mchr.state.md.us

MASSACHUSETTS

U.S. Department of Health and Human Services

Government Center, J.F. Kennedy Federal Building - Room 1875 Boston, MA 02203 1-800-368-1019, 1-617-565-1340 TTY/TDD: 1-617-565-1343 www.hhs.gov/ocr/office/

Office for Civil Rights, U.S. Department of Health and Human Services

Government Center, J.F. Kennedy Federal Building - Room 1875 Boston, MA 02203 1-800-368-1019, 1-617-565-1340 TTY/TDD: 1-617-565-1343 www.hhs.gov/ocr/office/ 6.

Civil Rights Commission Contact Information

(if you don't see your state, see District of Columbia) (con't)

MICHIGAN

Michigan Dept. of Civil Rights

Victor Bldg. Suite 700, 201 N Washington Square Lansing, MI 48933

1-517-335-3165, 1-312-886-2359

TTY/TDD: 1-312-353-5693 www.mdcr.state.mi.us/mdcr/

MISSOURI

Office for Civil Rights, U.S. Department of Health and Human Services

601 East 12th Street, Room 248 Kansas City, MO 64106 1-800-368-1019, 1-816-426-7277

TTY/TDD: 1-816-426-7065 www.hhs.gov/ocr/office/

Missouri Commission on Human Rights Dept. of Labor and Industrial Relations

3315 W. Truman Blvd., Room 212 P.O. Box 1129 Jefferson City, MO 65102-1129 1-877-781-4236, 1-573-751-4091

TTY/TDD: 1-800-735-2966

www.dolir.mo.gov

MONTANA

Dept. of Labor and Industry Human Rights Commission

P.O. Box 1728 Helena, MT 59620

1-800-542-0807, 1-406-444-2884

TTY/TDD: 1-406-444-9696

www.erd.dli.mt.gov

NEBRASKA

The Nebraska Equal Opportunity Commission

301 Centennial Mall South, P.O. Box 94934 Lincoln, NE 68509

1-800-642-6112, 1-402-471-2024

TTY/TDD: 711

www.nol.org/home/NEOC/

NEVADA

Office for Civil Rights of the West

4126 Technology Way, Room 100 Carson City, NV 89706 1-800-368-1019, 1-415-437-8310

TTY/TDD: 1-415-437-8311

www.detr.state.nv.us

NEW HAMPSHIRE

New Hampshire Human Rights Commission

2 Chenell Dr. Concord, NH 03301

Colicola, NH 0550

1-603-271-2767

TTY/TDD: 711

www.state.nh.us/hrc

NEW JERSEY

Department of Law & Public Safety

P.O. Box 090 Trenton, NJ 08625-0090

1-609-292-4605

TTY/TDD: 1-609-292-1785

www.state.nh.us/hrc

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia) (con't)

NEW YORK

Office for Civil Rights

26 Federal Plaza, Suite 3313 New York, NY 10278 1-212-264-3313 TTY/TDD: 1-212-264-2355

Office for Civil Rights U.S. Department of Health and Human Services

Jacob Javits Federal Building 26 Federal Plaza - Suite 3312 New York, NY 10278 1-212-264-3313 TTY/TDD: 1-212-264-2355

www.hhs.gov/ocr/office/

NORTH DAKOTA

North Dakota Dept. of Labor

600 E Boulevard Ave, Dept 406 Bismarck, ND 58505-0340 1-800-582-8032, 1-701-328-2660 TTY/TDD: 1-800-366-6889

 $\underline{www.nd.gov/labor/services/human-rights/}$

OHIO

Ohio Civil Rights Commission Central Office G. Michael Payton Exec. Direct.

30 East Broad Street, 5th Floor Columbus, OH 43215 1-614-466-2785, 1-888-278-7101 TTY/TDD: 1-800-750-0750, 1-330-643-1488

1-44---//--------/

http://crc.ohio.gov/

OKLAHOMA

Oklahoma Civil Rights Commission

2101 N Lincoln Blvd. Oklahoma City, OK 73105 1-800-368-1019, 1-214-767-4057 TTY/TDD: 1-214-767-8940 www.onenet.net

OREGON

(See Washington listing)

PENNSYLVANIA

Office for Civil Rights, U.S. Department of Health and Human Services

150 S. Independence Mall West, Suite 372, Public Ledger Building Philadelphia, PA 19106-9111 1-800-368-1019, 1-215-861-4441 TTY/TDD: 1-215-861-4440 www.hhs.gov/ocr/office/

Pennsylvania Human Relations Commission

301 Chestnut Street, Suite 300 Harrisburg, PA 17101 1-717-787-4410 TTY/TDD: 1-717-783-9308 www.phrc.state.pa.us/

6.

Civil Rights Commission Contact Information

(if you don't see your state, see District of Columbia) (con't)

SOUTH DAKOTA

South Dakota Dept. of Commerce & Regulation Division of Human Rights

118 W Capital Ave. Pierre, SD 57501

1-605-773-4493

TTY/TDD: 711

www.state.sd.us/dcr/hr

TENNESSEE

Tennessee Human Rights Commission

530 Church Street Suite 400, Cornerstone Square Building Nashville, TN 37243-0745

1-615-741-5825

TTY/TDD: 711

www.state.tn.us/humanrights/

TEXAS

Texas Commission on Human Rights

403 East Ben White Blvd.

Austin, TX 78704

1-800-572-2905

TTY/TDD: 711

www.dshs.state.tx.us

TEXAS

Office for Civil Rights U.S. Department of Health and Human Services

1301 Young Street, Suite 1169

Dallas, TX 75202

1-214-767-4056

TTY/TDD: 711

www.hhs.gov/ocr/office/

UTAH

Utah Anti-Discrimination Division

P.O. Box 146640, 160 East 300 South 3rd Floor

Salt Lake City, UT 84114-6640

1-801-530-6801

TTY/TDD: 711

www.laborcommission.utah.gov

VERMONT

Vermont Human Rights Commission

120 State Street Montpelier, VT 05620-4301

1-800-368-1019, 1-617-565-1340

TTY/TDD: 1-617-565-1343

www.hrc.state.vt.us

VIRGINIA

Council on Human Rights Suite

1100 Bank St., Suite 11-202 Washington Bldg. Richmond, VA 23219

1-804-225-2292, 1-800-633-5510

TTY/TDD: 711

www.chr.state.va.us

WASHINGTON

U.S. Department of Health and Human Services

2201 Sixth Avenue - M/S: RX-11

Seattle, WA 98121-1831

1-800-368-1019, 1-206-615-2290

TTY/TDD: 1-206-615-2296

www.hhs.gov/ocr/office/

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia) (con't)

Office for Civil Rights of Alaska, Idaho, Oregon, and Washington

2201 Sixth Avenue - M/S: RX-11 Seattle, WA 98121-1831 1-800-368-1019, 1-206-615-2290 TTY/TDD: 1-206-615-2296 www.hhs.gov/ocr/office/

WISCONSIN

Wisconsin Equal Rights Division Dept. of Workforce Development

P.O. Box 8928, 201 E Washington Ave. Room 407 Madison, WI 53708-8928 1-608-266-6860 TTY/TDD: 711 www.dwd.state.wi.us/er

WYOMING

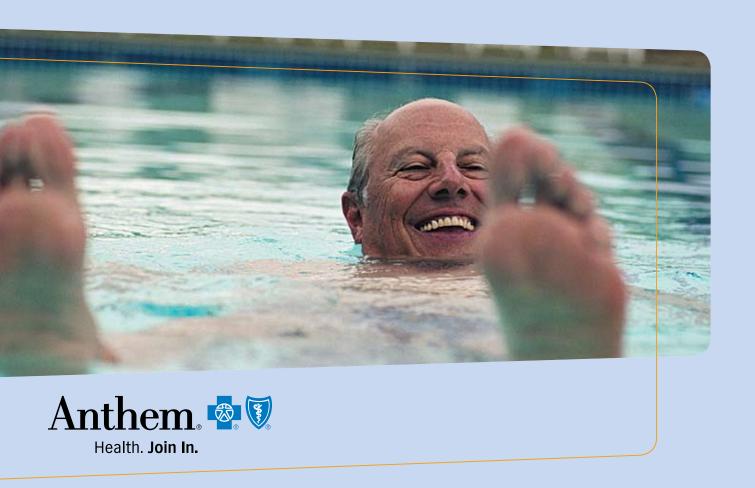
Wyoming Department of Employment Labor Standards Fair Employment Program

1510 E. Pershing, West Wing, Suite 2015 Cheyenne, WY 82002 1-307-777-4103 TTY/TDD: 711 http://wydoe.state.wy.us

For contract number H1689, Anthem Insurance Companies, Inc (AICI) is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFFS) noted above or herein. AICI is the risk bearing entity licensed under applicable state law to offer the PFFS plan(s) noted. AICI has retained the services of its related companies and the authorized agents/ brokers/producers to provide administrative services and/or to make the PFFS plan(s) available in this region.

For contract number H2613, Healthy Alliance Life Insurance Company (HALIC) is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFFS) noted above or herein. HALIC is the risk bearing entity licensed under applicable state law to offer the PFFS plan(s) noted. HALIC has retained the services of its related companies and the authorized agents/ brokers/producers to provide administrative services and/or to make the PFFS plan(s) available in this region.

For contract number H0540, UniCare Life and Health Insurance Company is the legal and risk bearing entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFFS) noted above or herein. UniCare, a separate company that does not provide Blue Cross and/or Blue Shield services, has retained the services of Rocky Mountain Hospital and Medical Service, Inc. or Anthem Health Plans of Maine, Inc. and the authorized agents/ brokers/producers to provide administrative services and/or to make the PFFS plan(s) available in this region.



Vendors in the Value Added Programs and their offers are subject to change without prior notice. We do not endorse and is not responsible for the products, services or information provided by the vendors. Services and supplies accessed through this program are NOT a part of your health coverage. Please refer to your benefit chart for coverage details. Information is being provided for educational purposes only and should not be considered medical advice or treatment. Please consult your doctor for advice about changes that could affect your health or lifestyle.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado and Nevada: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia (excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.): Anthem Health Plans of Virginia, Inc. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. IA_M0013_10GRP_022_07/13/2009, IA_M0013_10GRP_037_08/24/2009, and IA_C0003_09Grp_069_05/2009 through IA_C0003_09Grp_079 05/2009